ROLE OF FEDERAL FOOD ASSISTANCE PROGRAMS IN STRATEGIES TO REDUCE INFANT MORTALITY

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BEFORE THE

DOMESTIC TASK FORCE

OF THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

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ROLE OF FEDERAL FOOD ASSISTANCE PROGRAMS IN STRATEGIES TO REDUCE INFANT MORTALITY

THURSDAY, APRIL 29, 1987

House of Representatives,
Domestic Task Force,
Select Committee on Hunger,
Washington, DC.

The task force met at 9:35 a.m., in room 2255, Rayburn House Office Building, Hon. Leon E. Panetta (chairman of the task force) presiding.

Members present: Representatives Leland, Fazio, Dorgan, Espy, Flake, Gilman, and Smith.

OPENING STATEMENT OF HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Panetta. The Domestic Task Force of the Select Committee on Hunger is now in session for the purpose of reviewing reports relating to hunger and malnutrition in the United States, particularly as they relate to infant mortality.

Over the past three decades the U.S. infant mortality rate has declined from 6th among the top 20 industrial nations to a tie for last place. That is a sad commentary on a society like the United States. Hunger itself is a national shame. When you add to that a growing infant mortality in our society, it becomes a national tragedy.

Our poor record has worsened in recent years. The Children's Defense Fund has documented our lack of progress in what I believe to be an excellent report released early this year.

We're honored this morning to have as our first witness the president of the Children's Defense Fund, a friend and very eloquent leader in this area, Marian Wright Edelman.

Some of the statistics on our record which the Children's Defense Fund report documents are the following: Between 1983 and 1984, infant mortality rates increased in 6 of America's 22 largest cities. After a nationwide increase in the mortality rate among infants 28 days of age to 1 year of age in 1983—the technical term for infant mortality among this age group is the postneonatal mortality rate—this measure in 1984 declined back to the unacceptably high 1982 level.

In 1984, for the 5th consecutive year, there was no progress in reducing the percentage of infants born to women who received late or no prenatal care. And at the current rate of progress, the

Nation and the States will fail to meet nearly all of the Surgeon General's 1990 objectives for reducing infant mortality, the number of low birthweight births, and the number of women who receive late or no prenatal care.

While the causes of infant mortality are complex, and the provision of adequate nutrition alone will not solve the problem, programs are now in place which could end hunger and malnutrition, significantly reducing infant mortality.

I think it distresses me and a number of others that we are not willing to make the resources available to adequately fund the programs that could most help in this area.

The best example of that failure is with regard to the Special Supplemental Food Program for Women, Infants and Children, the WIC Program, which clearly has a proven track record of reducing infant mortality and low birth rates. WIC also has a proven track record of reducing Government health care costs.

Tragically, due to funding constraints, WIC comes nowhere near meeting the need. More than 5 million women and infants eligible for WIC benefits do not receive them because the program only serves 39 percent of those eligible. The cost to fully fund the WIC Program would be nearly $3 billion over the current funding level.

The long-run cost of our failure to solve this issue is even greater to our society. We have to recognize that in dealing with these issues, we are not only concerned about human life, which is obviously our most prevalent concern, but also with the fact that we're wasting a lot of money. And if we just made a small investment in some of these programs, the return on that investment for the future would not only save us money, but save us lives. And that's really what we're talking about here.

By failing to fully fund these programs we're not only sacrificing lives, we're also sacrificing whatever investment we're making at the present time, and only increasing costs to our society in the future.

We're privileged this morning to have a number of experts on the problem of infant mortality that can tell us how to reduce it. But we, in turn, as elected officials, must translate this knowledge into effective, adequately funded programs so that we can reverse our shameful record of unacceptably high infant mortality rates.

There is a price to be paid here. There is a price to be paid for not funding these programs, and that's something I think that we often ignore, that somehow a cut in these programs isn't going to cost us anything. It's going to cost us a great deal.

It's not just the homeless on the streets, and it's not just the increased numbers of people that are going to soup kitchens and food pantries, but, more importantly, it's the loss of lives, particularly among our children. And that's something I think we just need to focus on.

The American society doesn't recognize what a high cost we're paying for not adequately funding these programs. And hopefully this kind of hearing will help draw attention to that urging problem in our society.

[The prepared statement of Mr. Panetta appears at the conclusion of the hearing, see p. 47.]

Mr. **Panetta**. Mr. Leland.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman **Leland**. Thank you, Mr. Chairman. I join with you, Mr. Chairman, in welcoming to our examination all of the wonderful people who have come here to testify about this incredible problem.

The National Center for Health Statistics reports that for 1984, the most recent year for which final statistics are available, the infant mortality rate reached a record low of 10.8 infant deaths per 1,000 live births. I applaud the fact that over the last two decades we've experienced a decline in the number of babies in this Nation who die before their first birthday. However, I would be remiss if I failed to state my concern and chagrin that this overall statistical improvement masks the sobering truth.

Aggregate statistics hide the following facts: the infant mortality rate among blacks is twice that among whites; the infant mortality rate among infants of all races in poor rural counties has increased significantly in recent years; and, five of the Nation's largest cities have infant mortality rates more than 1½ times the national average.

In a recent select committee telephone survey of infant mortality statistics for 1984 and 1985, 11 States reported an increase in the rate for whites and 16 reported an increase for nonwhites. These numbers sound an alarm.

While the data is subject to further study, the preponderance of evidence from so many States shows clearly that the United States is falling behind in its effort to lower the infant mortality rate. Surely a country as wealthly and as powerful as the United States can offer no excuse when infant mortality rate that is worse than 16 other industrialized nations—last in the class of industrialized nations as was alluded to by the chairman of this task force.

We are aware of many interventions which can prevent infant deaths. We are here today to examine three critical components of any comprehensive national strategy to achieve this goal; assured access to nutrition services, health care, and income support.

No one can provide information on how many infant deaths result from any one particular cause. However, we know that millions of women and children in this country endure poverty and fail to receive adequate medical services and nutrition assistance which, as Boston Mayor Raymond Flynn has stated, gives new meaning to the phrase "women and children first."

Recent research from the Department of Health and Human Services found that adequate nutrition during pregnancy can prevent low birth weight, the leading cause of infant mortality, among even those women who are otherwise considered high risk.

Similarly, a recent Department of Agriculture evaluation of the Special Supplemental Feeding Program for Women, Infants and Children, revealed that the integrated food, education, and medical care components of the program significantly improve maternal and child health. Yet, only approximately one-third of the income eligible reap the benefits of this participation.

We know what works and what solutions are cost effective. It is time for us to target our resources on this critical problem. I encourage the witnesses today to provide us with recommendations for a coordinated Federal plan by the Departments of Health and Human Services and Agriculture to ensure that mothers and infants in need receive proper comprehensive prenatal and postnatal care.

Thank you, Mr. Chairman.

Mr. PANETTA. Mr. Fazio.

OPENING STATEMENT OF HON. VIC FAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FAZIO. I have no statement except to express my appreciation to both you and Mr. Leland for the leadership that you provided calling this hearing. We have an excellent list of witnesses to discuss what is obviously a shameful and, given the resources of this country, disgraceful situation that exists in many pockets around the Nation where infant mortality is at such rates that we challenge the concept that this is a Nation dedicated to public welfare.

So I look forward to hearing all the testimony and the plan of action that I think this committee can help formulate to help deal with the problem.

Thank you.

Mr. PANETTA. Mr. Dorgan.

OPENING STATEMENT OF HON. BYRON L. DORGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. DORGAN. Mr. Chairman, I regret that I'm going to have to be absent for part of this hearing, but I hope to be back about 11 a.m. I did want to say that this subject is very important. In the chairman's remarks, Mr. Leland, he made reference to the WIC Program which in my judgment is one of the finest programs that we've ever developed at the Federal level.

And having toured WIC centers in North Dakota, and I suspect that many of you have done the same in your districts, I've discovered once again there's a long waiting list on the WIC Program roles. I hope that we can deal with those kind of things in this committee and in Congress because those are the kinds of programs that are targeted to, are extraordinarily important and valuable to low income people. They not only save lives, but also create healthy babies.

I was pleased to note the reference in the chairman's remarks and hope that we can discuss the WIC Program this morning.

Mr. PANETTA. Thank you. Our first panel is Mrs. Marian Wright Edelman and Dr. Linda Randolph, if you would come to the witness stand, please. Mrs. Edelman, as many of us know, I think, is the founder and president of the Children's Defense Fund, which is an organization that's dedicated to the health and well-being of children in America.

Dr. Randolph is the director of the Office of Public Health for the State of New York, a post that she's held since 1983.

I want to thank you both for joining us this morning and look forward to your testimony. Marian, if you would proceed.

STATEMENT OF MARIAN WRIGHT EDELMAN, PRESIDENT, CHILDREN'S DEFENSE FUND, ACCOMPANIED BY KAY JOHNSON, SENIOR HEALTH SPECIALIST

Mrs. **Edelman**. Thank you. I want to thank the chairman and Mr. Leland and members of this committee for caring so much about this critical issue and holding this hearing and providing a needed voice. If this country can't save its babies in the first year of life, I'm not sure what we are capable of doing.

I think that it's time for us to reach a consensus within this Congress that this is something we're simply going to do as a nation, because I think the survival and quality of our children, our youth and our families are the single most important determinant to the quality of the national future.

And at a time when we have a shrinking number of young people who are going to be that work force in the year 2000 and ensuring the healthy birth and the healthy development of every one of our children is critically important. So thank you for what you're doing, and I do hope we can translate this into very specific actions because the cost of neglect exceeds, in my view, the cost of investing in healthy infants.

Second, my staff has written—we have prepared a written statement which will be submitted for the record. They'd love it if you'd put every footnote, the entire new data book on The Health of America's Children in the record, but we'll——

Mr. **Panetta**. Without objection, your prepared statement will be inserted in the record.

[The data book referred to above retained in committee files.]

Mrs. **Edelman**. But we do submit that to you for use in anyway you feel feasible. One of our goals at the Children's Defense Fund is to see that the unmet health needs of all of our infants and children are ensured, including the right to have access to comprehensive medical care before birth and after birth.

I would just like to begin with one story which is the kind of story that we get too often in our office, and which we just simply should not have in America. And I hope that Mr. Leland won't think I'm picking on the State of Texas, where we've been spending a lot of time trying to provide indigent health care, but one of the recent stories comes from Brownsville, which has a particular problem.

Chairman **Leland**. I don't mind picking on Texas.

Mrs. **Edelman**. I understand. We don't mind picking on Texas either, and Texas needs a lot more picking on in terms of health care for its babies and mothers. But one story that came to us last year, which we are following up on because it's a pattern in Brownsville, occurred on September 12, 1986 when Gloria A., who went into labor in Cameron County, her family, like hundreds of other families in Cameron County, had no savings and no health insurance and, you know, one in six of our children has no health insurance coverage.

They planned to have a home delivery with a midwife, but it soon became evident that the mother's labor was not going to be normal. She went to the community health center where she had received prenatal care. The attending obstetrician discovered that her baby was in a breach position and determined that an immediate Cesarean section would be performed or should be performed.

They placed Mrs. A. on intravenous equipment and got her into a medical van. The physician called the hospital to say that he was admitting a patient for an emergency delivery. When she and her husband arrived at the hospital she was not admitted, as her physician had instructed. The hospital refused to accept her because the family was poor and uninsured.

Texas provides a special program for indigent women like Mrs. A. that would have helped pay for the delivery. The hospital refused and has refused to participate in this program.

The other hospital in Brownsville also refused to admit uninsured patients, and the next closest hospital with obstetrical facilities that might admit someone of this mother's limited means was 35 or 40 miles away.

While she was in active labor she was met by a member of the hospital business staff who informed her that because she and her husband were not insured she would have to pay $3,000 in a preadmission deposit in order to be admitted. The delivery actually would have cost about $1,500.

The staff person told her that if they insisted upon being treated without paying, the hospital would bring a collection action to repossess everything they owned and for poor folks this can be quite scarey.

Shaken by this and frightened by the threats, she and her husband left the hospital. They were not permitted to leave until she signed a form stating that she was leaving against the medical advice of the hospital.

Mrs. A. finally delivered her baby a day later at a hospital that admitted her without charging her. As a result, the baby's umbilical cord had collapsed. The oxygen flow to the brain was restricted. The physicians do not know at this point whether the infant will suffer lifetime disabilities as a result.

Every child needs decent health care at every stage of development. Comprehensive prenatal care provided throughout a mother's pregnancy, labor, and delivery should continue throughout childhood with the child's preventive, acute, and chronic health care needs met.

No pregnant woman should be denied maternity care because she does not have the money to pay for it, and thousands are denied that right every year. No child, whatever the need, whether it's for immunizations, treatment for strep throat, hospitalizations, medicines, speech therapy because of a hearing loss, or long-term care at home, should go without health care because his or her family cannot afford it.

Preventive care during all stages of the child's life pays off not only in improved health, but in financial savings and society, as the chairman has already pointed out.

We can and know what steps we can take to reduce mortality and low birthweight among infants. We know that early and continuous maternity care can reduce mortality and low birthweight among infants by more than 25 percent. We know that low birthweight babies are 20 times more likely to die in the first year of life and face significantly higher risks of disability.

Thus, by reducing low birthweight, birth defects, and infant death, we not only save infant lives and mother's health, we save society dollars. For every hour that high quality prenatal services postpone the birth of a premature infant, our society can save about $100. Every dollar spent to provide prenatal care saves more than $3 in the first year of that infant's life alone.

By reducing the need for expensive hospital stays among babies, that same dollar saves an average of up to $11 in total medical expenses over the lifetime of a child because that child is less likely to be born with permanent disabilities.

First, I think that this Nation has to reach a concensus that we must provide total access to comprehensive prenatal care to every mother, and in doing so I think we will make significant progress in reducing infant mortality and in improving our international standing among the world's leading industrialized nations. One of the things that I was very struck by in looking at the new international data is that Japan started off last when we looked at the 1950 to 1955 period. They are now at the top, as you know.

And, as you indicated, Mr. Chairman, we started off in fifth place and now we're at the bottom and I think that says something about our focus.

Second, I think we must try to begin to remove some of the enormous barriers that are faced poor mothers and kids who need health care. And, third, we need to improve and bolster our most important public health and nutritional programs which we've allowed to stagnate and erode and, in many ways, have been reduced outright.

You've already laid out the facts and I will not go back into that about the increasing infant mortality rates in some of our large cities, about our falling backwards in terms of our industrialized nation peers, in terms of the postneonatal mortality increases, which again are poverty. The babies that are dying between 30 days and 1 year of life are those that are not low birthweight babies. Those are the babies that may be born full term, come home, and they are not thriving that first year of life. That's poor housing, that's inadequate nutrition, that's just plain old poverty, which afflicts our children more than any other nation, any other group in our country.

What must we do in order to improve this? First, I think it is terribly important that we bolster the Medicaid Program which is the major health insurance program for families with children. And, sadly, in light of the growing uninsuredness and growing unemployment, it is serving fewer children than it served earlier.

The Congress has made significant improvements for which we thank you very much, but we have not been able to keep pace with the growing needs. But I think it is important that we work for full implementation of the new provisions in Medicaid, though those new laws will still not fill all of Medicaid's gaps—it still will not reach many of the low-income children after they have turned 5.

There are 20 States that continue to deny Medicaid to very poor children older than 5 who do not receive AFDC because they live with both parents. And all of us should check our States to make sure that they are taking advantage of the new Medicaid provisions that you have enacted.

Neither do these new laws aid millions of uninsured, nonpregnant poor parents whether they are working or unemployed. I think we must begin to fill in the gap in Medicaid so that we can see that no child and no mother is uninsured. And that is one immediate step.

Second, we're going to have to take steps to close the gaps in our public and private health insurance systems that still leave millions of our children uninsured. We have about 34 million Americans who are not insured. One out of 3 poor children and 1 out of every 3 women of childbearing age is uninsured. And that is just something we cannot afford.

And among—I think we stand with South Africa, probably, as the only nations who are not providing the kind of basic survival health coverage for our mothers and children.

Third, we've got to improve the funding of what now adds up to a limited network of health care programs, but again they're not able to reach out and serve millions of needed mothers and children. Our Maternal and Child Health Block Grant Program, our community and migrant health centers, our Child Immunization Programs, and most importantly WIC, we just need to make sure that they add up to a more comprehensive approach.

At the moment the way they are now—programs that leave millions of Americans uninsured. We have specific recommendations of what this Congress ought to do in order to ensure a minimum of health coverage by 1992. Again we understand that we are in a deficit reduction situation, one of the things we need to do is to turn around the argument on its head because precisely because we're in a deficit reduction situation it should compel us to invest in these problems before they occur because it's a whole lot more cost effective and cheaper to deal with the comprehensive prenatal care than to deal with the long-term disability effects of hospitalization and the rest.

But one of the goals we should set this year and follow through incrementally each year between now and 1992—we should be heading somewhere that's positive—is that no woman or child who is eligible for the Supplemental Nutrition Program under WIC should go without these benefits.

Our legislative agenda this year, the Children's Defense Budget calls for sufficient funding to increase participation rates substantially for each of the next 5 years, so that by 1992 all eligible needy women and children are served. If you want to do it faster, that's even more terrific. But we think that as a minimum, a slow incremental approach to encouraging the basic nutritional programs. We know, again, it works, and we know it saves money.

Second, I hope we can move this Congress to committing itself to providing all families with access to affordable, adequate health insurance. We recommend a gradual phase in of such a program.

Specifically we ask this committee's support in ensuring the fiscal 1988 budget contains sufficient funds to enact H.R. 1018 and Senate 422, which are called the Medicaid Infant Mortality Amendments of 1987, which would expand pregnant women, infants and children's eligibility for Medicaid.

The next step would be to permit States to extend Medicaid to all members of families and all individuals living below the Federal poverty line rather than only young children and pregnant women.

In addition, we propose that States be given the option to institute a program under which uninsured moderate-income families with incomes above the Federal poverty level would be able to purchase Medicaid for an income adjusted premium.

CDF recommends that within the next 10 years this program will be instituted nationwide for all individuals and families without group health coverage. Funding would come from a number of sources, including individual premiums, general revenues, dedicated taxes such as a small employer payroll tax, and a surtax on all group health insurance plans. No American should be without some basic access to coverage.

Third, all families should have access to affordable appropriate health providers. We recommend funding for the title V maternal and child health block grant and for our community and migrant health centers which are particularly important in California and Texas. And this funding should be sufficient to permit the development of health services in all medically underserved areas.

Specifically we ask for inclusion in the budget of sufficient funds to enact H.R. 1326, which would provide $30 million to assist community and migrant health centers combat infant mortality.

Last, all children should be adequately immunized against all preventable childhood diseases. And I'm finding it astonishing that we have to stand here and say that to you at a time in 1987 when we have one-half of all black preschool children not fully immunized against preventable diseases.

We recommend prompt implementation of the National Childhood Vaccine Injury Act in order to better control the price of vaccines as well as conversion of the next five of the child immunization program into an entitlement programs.

New goals must be established if the Nation is to achieve an acceptable level of improvement in infant and child health. These new goals cannot consist simply of improved health outcomes, but also must include the programmatic commitments that make these goals a reality.

And we must recognize that some new investments to meet these programmatic commitments should be measured against what they will save the Nation over the long-term in money and in human suffering.

We look forward to working with you. We think that these are practical, feasable, cost effective steps that are long overdue.

I just want to say that I think the Nation is ready. I think we really have sensed a movement in the country. People are shocked at the growing misery among children. They are shocked that they are now uninsured and realize that everybody is one job away from health uninsuredness and from the food stamp lines.

So, I think we've now reached a critical mass of misery, but, more importantly, I think more and more Americans are coming to recognize the importance of preventive investment. I think these are going to be the debates of the next decade, and I'm glad that this committee is out ahead trying to lead it. But there's going to be an outside constituency for it, and I thank you for your work.

Mr. **Panetta**. Thank you very much.

Dr. Randolph.

[The prepared statement of Mrs. Edelman appears at the conclusion of the hearing, see p. 50.]

STATEMENT OF LINDA A. RANDOLPH, M.D., DIRECTOR, OFFICE OF PUBLIC HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH

Dr. **Randolph**. Thank you very much. I am very pleased to be here this morning on behalf of Governor Cuomo and Commissioner Axelrod. This issue is obviously a very important one.

This morning I will summarize my prepared statement which you have, and describe for you what New York State has attempted to accomplish in this area.

In the late 1970's we began with Federal assistance an Improved Pregnancy Outcome Program which is really designed to get at one of the issues just mentioned earlier, to develop statewide data on prenatal and perinatal mortality, on poor birth outcomes, and on the need for prenatal services.

Emphasizing that the analysis of data by small areas is very important because of the masking of the aggregate county and State statistics, this effort has helped to provide us the data base that has allowed us to target prenatal care services to areas and populations in greatest need. We also were able to put in place some beginning demonstration programs that helped us to develop protocols for prenatal care services, including health education and counseling services which are essential to sound maternal and infant health.

In 1983, with the Federal Emergency Jobs bill award, we again were able to fund 14 projects for the prevention of low birth weight through the provision of prenatal care and health education to women at high risk for poor pregnancy outcome.

And, at the same time, we began the development of an Infant Health Assessment Program, we call it IHAP, which is designed to ensure that babies born at high risk for developmental disabilities and infant mortality receive appropriate medical and psychosocial services following the hospital discharge. This program relies very heavily on county public health nurses to locate those infants, to connect them to needed care, and to serve as an ongoing tracking and followup system that is essential.

The other major service component in New York State to prevent poor birth outcomes and infant mortality, is our own State funded prenatal care and nutrition program. It is aimed at the medically indigent women below 185 percent of the Federal poverty level who are ineligible for Medicaid, who have no third-party coverage. It does provide for these women comprehensive prenatal care services free of charge that also address social support and education needs to low income pregnant women and their newborns.

That program began in 1985. It's supported with $18 million in State funds and consists of 89 projects in more than 115 service sites in 43 of the State's 57 counties and in New York City. It has served over 55,000 women since its beginning in January of 1985.

At the same time that we have sought to extend these prenatal care services to as many pregnant women as possible, we again felt the need to develop protocols of services to ensure that there would be high quality and comprehensive services being provided.

Nutrition counselling is an important part of the Prenatal Care Nutrition Program. All women are screened for nutritional risk conditions. And the intervention is tailored very specifically to the individual women's risk status.

The most common nutrition regimen for Prenatal Care Nutrition Program clients is enrollment in the WIC Program. We have found that WIC is the most practical, the most available, and the best proven means of improving the nutritional status of pregnant women.

We also know, however, in New York State, that funding for WIC has never been sufficient. And while New York State operates the largest WIC Program in the Nation, it still services only 45 percent of the eligible population who qualify for it. This figure is somewhat misleading in that at least 85 percent of all pregnant women who qualify are enrolled. We have subsequently added State moneys through the State Supplemental Nutrition Assistance Program to augment WIC to the tune of an additional $31 million in this current fiscal year which extends WIC coverage to over 50,000 more women, infants and children than the roughly 240,000 that we currently serve under the Federal program.

But in New York State we estimate that the eligible population for WIC is some 640,000 women, infants and children. So we still have a significant way to go.

At this point I would like to mention that in looking at that gap between unmet needs, we also began to undertake discussions with the U.S. Department of Agriculture to explore the possibility of New York State participating in the Commodities Supplemental Feeding Program.

We worked with USDA over 2 years to prepare a proposal that would allow us to jointly work with the voluntary sector in New York State to implement such a program particularly targeted at vulnerable women and children.

We were informed by USDA that their priorities for that program as of the Federal fiscal year 1987 was for expansion of existing programs in approximately 10 States in the country, and expansion of services to the elderly.

We feel that this particular program has great potential for expansion to the WIC eligible population. We believe that the administrative decision to set those specific priorities will not allow New York State and other States to participate in the program, and we would appreciate the Department of Agriculture reviewing its setting of priorities for that program.

No matter how elaborate or well planned the kinds of services that we have attempted to provide, we know that accessibility is clearly a problem. And as Marian Edelman has already mentioned, we strongly support all initiatives that would expand Medicaid coverage for prenatal care to women. We would support all measures in that regard.

We have currently before the State legislature in New York a Governor's program bill that would provide for universal access to prenatal care services to all women in the State of New York up to 185 percent of poverty. It is intended to be an entitlement program in the State of New York. It is an attempt to bridge that gap in terms of the working poor women who remain ineligible for Medicaid and have no insurance coverage.

And if we are successful in passing that State legislation along with other Federal legislation that is currently before the Congress, we believe that with the complementary Federal and State effort we will be able to reach the populations that we've been trying to reach to date.

I would reemphasize that in New York State, while the infant mortality rate in the State has been decreasing over the years, we do have parts of our State, both in New York City and in upstate New York, where the infant mortality rates are at least twice State average figures.

We know, as has been mentioned before, a lot about what works. We know that we need to have programs available for prenatal care, we need to be able to have increased enrollment in WIC and other nutrition programs, and we need an expanded Medicaid and State fiscal support services to pregnant woman, and we know that that will have an effect.

We must deal with the issue of outreach. We must deal with our seeming inability in many parts of the State and in many parts of the country to identify women early and bring them in early for care. We know that finances are a major barrier to that access. But we also recognize that there are other barriers to care, and we need to have a coordinated approach that will make information and services available that are tailored to the cultural and ethnic diversity of our States and in our country.

We believe that we can redouble our efforts both in New York State and in the country as a whole. We look forward to the recommendations and deliberations of this committee to assist us in this effort. I am available for additional questions and comments.

[The prepared statement of Dr. Randolph appears at the conclusion of the hearing, see p. 86.]

Mr. **Panetta**. Thank you very much, Dr. Randolph. As always, I'm going to apologize in advance because today we're taking up the trade legislation and we have a vote on the floor, so we're very likely to be interrupted for votes during the day.

We do have a vote that's on now, and the Chairman of the Select Committee has gone over early. When he returns he will commence questioning and then we'll return to do that. But right now for the vote I'm going to declare a recess for 5 minutes and then we'll be back for questions.

[Recess taken.]

Chairman **Leland**. Let me resume the hearing, if you will. I would like to ask that our panelists come back to the witness table.

Mrs. **Edelman**. I'm asking Kay Johnson of our staff to come to answer any hard questions you've got about any specific legislation, Mr. Chairman.

Chairman **Leland**. Very good. If you will just identify her for the purpose of the record we'd appreciate it.

Mrs. **Edelman**. Kay Johnson, who is the senior health specialist at the Children's Defense Fund.

Chairman LELAND. We welcome her participation.

Mrs. EDELMAN. Mr. Chairman, may I say one more thing because the other thing I forgot to say is one other strategy——

Chairman LELAND. Without objection, your statement will be included in the record.

Mrs. EDELMAN. Wonderful. But the other thing that we all have got to deal with, to have another measure to take to prevent infant mortality, is to prevent teenage pregnancy, because our teens are very vulnerable. They are the ones who are least likely to come in for early prenatal care, they are the ones who are most likely to have low-birthweight babies, that are at risk of infant mortality and low birthweight.

So one other companion piece which we are trying to put into place at the Children's Defense Fund is a massive national campaign to prevent teenage pregnancy because again, 13-, 14-, and 15-year-old mothers are more less likely to admit that they are pregnant early and our health care system does not reach out to them effectively.

So that's one whole set of strategies that should be added here to efforts to prevent teenage pregnancy. There are a range of ways that we now know that one of the things that we've got to do to prevent teenage pregnancy is to deal with the hopelessness that comes from poverty of young people who have no sense that they have anything to lose by having a baby early, and by ensuring that every young person has good, strong, basic skills, and a feeling of competence in schools and the sense that there's a job out there.

So again, we've got to put into place positive life options as well as to target health services on those young people who may already be pregnant or parents to prevent both that second birth and to ensure that that first birth doesn't come with extra risk.

I didn't want to leave that as a gap in what we ought to be thinking about.

Chairman LELAND. Thank you. I'd like to come back to that. But first, let me make reference to the fact that you alluded to a severe Texas problem and asked for apologies if they were necessary for the purpose of your making reference. I recognize the problem in Texas. I also know that our legislature, that great body of which I had the opportunity to serve for 6 years, has not really committed the kinds of funds that are necessary in a priority way for us to alleviate the very critical situation of infant mortality, but the other problems that afflict impoverished people with regards to health care.

There was one initiative taken up during the last session of the legislature which offered honorable intention. However I should say it would not provide nearly enough assistance.

I remember in 1974 during the constitutional convention of the State of Texas, as a delegate I proposed an amendment to the constitution to provide every resident of the State of Texas the right to adequate and comprehensive health services. If we had passed that proposal, it would have been a constitutional right in the State of Texas for every resident to receive adequate and comprehensive health services.

In Texas numerous cases involving the refusal of treatment to uninsured persons have been cited. Yet, Mrs. Edelman, legislation requiring treatment for these individuals has been enacted.

Mrs. **Edelman**. That's right.

Chairman **Leland**. To what factors do you attribute the continuation of these denials for medical assistance?

Mrs. **Edelman**. Well, I think, Mr. Chairman, as we all know, passing the laws are an important first step. The antidumping provisions in the indigent health care legislation, which we did, along with the March of Dimes, work very hard for and for which we are working very hard to retain the funding in the current legislative session because, as you know, the Texas economy is not as it's best, but so far it's holding.

But I think that gets back to implementation, and it takes a long time once a law is passed to get the regulations written, to inform the public of its rights, to really seep down through the system. When you've got recalcitrant hospital administrators, as we tend to have in Brownsville, TX, and some other places, it becomes difficult.

So there has to be a commitment to following through, to publicizing these kinds of denials of care, which I think most Americans and most Texans would find shocking. I think by bringing more light to bear, by having the Texas Health Department really follow up in trying to implement those new provisions, and by, when necessary, litigation. We at the Children's Defense Fund are considering litigation against the Brownsville group because it is a pattern of practice. But I think that one has to constantly challenge.

I think that the real crunch is a real commitment to follow through because there really are too many incidents not only in Texas, but around the country. I mean, the stories of pregnant women being turned away in labor because of their inability to provide a preadmission deposit are just a scandal in this Nation.

So I think our Federal Department of Health, Education, and Welfare also has to have followup policies. And, on the whole, there has been almost no enforcement in this administration of these kind of provisions on behalf of the poor and, in fact, they have sent out a negative signal by their cutbacks in health care for the poor and they've made no effort to lift a hand to implement antidumping provisions and to challenge these kinds of practices. So the burden, therefore, has been shifted to the private sector.

But the key has got to be in enforcement, in throwing light and having hearings, and, indeed, we have encouraged this committee to go out in the various States where this is a pattern and to hold hearings and to let the American public know the kinds of practices that are going on.

Chairman **Leland**. Let me ask——

Dr. **Randolph**. Can I add to that?

Chairman **Leland**. Very definitely.

Dr. **Randolph**. In addition to that, I think it's important in looking at the provision of prenatal care services that there's a spectrum of care and that prenatal care services and labor and delivery services are a continuum.

To the extent that we can, we must create a delivery system that recognizes and appreciates the necessary linkages to assure a planned relationship between the prenatal care provider and the delivery provider.

And so, in mounting programs and attempting to provide funding for those programs, if you make those stipulations in the program package itself setting a continuum of care standards, you will begin to create a scenario wherein decisions such as prebooking for hospital services will be made. You can also assure accountability on the part of the provider.

Chairman LELAND. I'm so glad you're here. Your comments will be very helpful. One thing that has remained a very stark reality with this committee in its work not only here in this country, but in other parts of the world, is the fact that feeding people and providing adequate nutrition for people is inextricably tied to good health.

How can we better integrate the food assistance programs with the health assistance programs? That question is open to the panel.

Mrs. EDELMAN. Kay, do you want to answer that?

Ms. JOHNSON. I have all the microphones pointed at me. I must speak. There have been a number of discussions, particularly since the 100th Congress began, about how we might go about doing this, and in prior years there have been a number of discussions about how we might go about doing this.

I think that one of the fundamental problems again is the inadequacy of our programs. It is hard to link the Medicaid and the WIC Program when we don't have the ability to cover many of those who ought to be in the Medicaid Program, and we don't have the ability to cover many of those who ought to be in the WIC Program.

As an example, the proposals in the initiative embodied in H.R. 1018 and S. 422 would, I think, bring further highlight to the need to link these programs by bringing the States the option to raise Medicaid eligibility levels to be in tandem with WIC levels.

So if we had those programs parallel in a State like New York, we would be able to say here is a women who is eligible for Medicaid, she is also eligible for WIC, we know that she ought to be in both programs.

An example of where that's been done is Arizona where they have linked, for children, the Food Stamp Program with Medicaid eligibility up to 100 percent of the Federal poverty level. So every child who is in a family who receives food stamps in Arizona is entitled to a Medicaid card.

I think we can build those linkages, but only when we broaden our programs and cover those who should be covered.

Chairman LELAND. You're an advocate of one-stop shopping, in other words.

Ms. JOHNSON. Absolutely.

Chairman LELAND. We've asked for a General Accounting Office (GAO) study of the merits of providing one-stop shopping for these purposes. I must say that one of our colleagues on the committee, Representative Bill Emerson, has been a fervent supporter of the one-stop shopping concept.

For some reason we've had certain delays with GAO. I know it's been a rather lengthy investigation. We hope that we can come to some resolve at some point.

Based on the Children's Defense Fund research, what are the primary barriers to participation in the Food Stamp, WIC, and Medicaid Programs?

Mrs. **Edelman**. One is just getting access. We just don't have the coverage. There are millions of folk who are just outside the range of coverage under Medicaid. And so, given the limitations of coverage and eligibility and all of these I think Medicaid expansion is the first major thing.

Second, in addition, obviously we've got transportation barriers, we've got child care barriers, we've got language barriers. I think in Texas and California you're getting into care for the non-English speaking, and again that care needs to be available and it needs to be humane and it needs to be provided in a manner in which people will be able to take advantage of it.

Again, third, for teens, very little of care is accessible—both the hours and the targeted nature of that coverage makes it unwelcoming for many teens. That's why one is having the current debate about how can we take the health care to locations where young people are, in and out of housing projects or in and out of schools, so that they can find it more accessible and more welcoming.

So I think that barriers include lack of access, which comes from poverty and an inability to pay for care, and then second, the fact that it's not provided in a manner which allows people to take advantage of it once it is provided; and, third, the outreach issue.

Health education outreach is terribly important, particularly for high-risk populations. We need to be more imaginative in how we reach out of school young people or how we reach high-risk pregnant women. I'm beginning to think that the disc jockeys may be the more important group or the folks at the gospel stations may be more important—people don't read. So I think we're going to have to be very imaginative in trying to reach out into the segments of the society who are the folks that we need to reach, and we have not been particularly imaginative.

It seems sometimes that our goals are to make sure that people don't know about the services and don't come, and therefore don't cost us money. So I think we've got to do all of these things if we, in fact, are going to have the kind of coverage that we need to have.

Chairman **Leland**. Let me now ask the gentleman from California if he has any questions.

Mr. **Fazio**. Thank you, Mr. Chairman. I guess I'm a little guilt-ridden here coming from a State that is 6th in the Nation in terms of per capita income, with a 33-percent participation in the WIC Program. We clearly are below the national average of 40 percent.

And I look at New York which has been struggling with the loss of corporate centers, et cetera, and you're at 45 and doing more with State funds.

I wonder if you could tell us, Marian, where you see a clear distinction between the way these two large States are functioning in terms of getting more people to be participants in the program. I think you alluded to the language problem and the large Hispanic population. But I want to give our friends from New York a chance to brag on us a little bit.

What can we do in California to catch up with the Empire State?

Mrs. **Edelman**. Now, the Empire State is doing good in some ways. We shouldn't overstate that. The Empire State has got some very real problems.

Mr. **Fazio**. I knew you'd do that, so I thought I'd build it up. [Laughter.]

Mrs. **Edelman**. I am glad to hear that they're—and I really applaud Dr. Randolph's leadership, but I think they particularly need to work on their access to early prenatal care, particularly among minority women where they're doing not as well as Mississippi in some ways.

We've been singling out New York for its great leadership, but I'm sure we're going to get it and we're going to get that prenatal care bill through, and I think that's terrific.

I'm going to defer to Kay to talk about California. I mean, obviously everybody needs to do better on WIC. Again, I think that it would be very helpful if those of you who are here in a Federal position to help us ride your States.

Mr. **Fazio**. That's what I'd like to do. I'd like to give them specific ideas.

Mrs. **Edelman**. There are a number of States that are doing a very good job. It all boils down, all the time, to leadership and to having somebody in that State that really wants to have it done.

So, Kay, if you want to talk specifically about California, that would be great.

Ms. **Johnson**. Well, I think that we know that New York is not the only State who is providing supplemental funding for the WIC Program. I think we would hope that that would go on in a number of other States.

There are only five or six States that are doing that at this point.

Mr. **Fazio**. Would you provide those for the record if you don't have them in front of you?

Ms. **Johnson**. I certainly could provide them later for the record. Those States have seen the need to have supplemental funding because the programs are so inadequate, and they have been willing to put it in place. That is certainly something that could go on across the Nation, including in California, particularly in this interim if we're talking about a 5-year plan to improve the overall funding levels for WIC.

We would not like to see those families go without that support during the next 5 years, and State funding could certainly be of benefit there, along with bringing the WIC and Medicaid Programs in-line, so that they're somehow parallel. We are certainly hoping that States will have new options to extend Medicaid coverage to pregnant women and infants and to children this year.

We would like to see California be one of the States that moves toward implementation of last year's improvements and toward implementation of further improvements that are passed by Congress this year.

California has been a State that selected options in previous years. It does now cover all of the children 5 to 18 at State option only, and we would hope that they would do that. They could go up to the 100 percent poverty for pregnant women and infants right now. They could have moved on April 1st, but they haven't made the move in that direction so far.

Mr. FAZIO. I think Mr. Panetta might want to talk with you and several of us might want to try to generate some support for my delegation——

Mrs. EDELMAN. We'd be delighted to write you a very specific letter on the steps that California could take and try to cause those out for you.

Mr. FAZIO. Well, this is something we may want to try to get behind as a delegation.

Mrs. EDELMAN. That would be great.

Mr. FAZIO. One other question, Mr. Chairman, and it may relate to mind set which creates this problem in California. California has a new USDA, Dick Lang, who in testimony before the budget committee this year on the WIC issues testified very clearly that he believes there are ineligible people receiving WIC assistance. I disputed that, but I'm not as effective in doing so as you would have been had you been in my shoes.

I'm wondering if you can document for us, it's certainly a test to your beliefs, as to whether or not this is a program where we have any degree of waste, fraud, or abuse, where we have any percentage of an affluent or middle class constituency getting service.

The failure to increase the budget this year to keep pace with our current case load, as least as the USDA budget was submitted, was predicated on the belief that we are not doing a job of targeting.

Would you respond to that?

Mrs. EDELMAN. I think it is our perception, and Kay can correct me, that there is not a lot of abuse in the WIC Program. By far the greatest problem is not getting the program to those who need it rather than whatever very small percentage may abuse it. There are always going to be some folk who abuse programs, but I think that that's minimal here.

Without doubt the overwhelming job before us is to see that nobody gets denied this program. We do need it because we know that it works. I do wish in this country, because this is the rationale that we use generally, I wish we'd apply the same standards of nonwaste to our rich—our corporate welfare and to our rich folk welfare that we tend to proceed with in the case of the poor.

But I think it's time for us to get into the business while we all are in favor of efficiency and of targeting. That gets back to oversight hearings and follow through, which we favor a great deal across the board. But I hope we can begin to move beyond trying to set our policies based on the one-tenth of 1 percent of people who cheat and try to really focus in on the 99 percent of those who really need it and who try to use it in a way that is intended by this Congress.

Mr. FAZIO. Have there been any studies at all done to document those——

Mrs. EDELMAN. We are not aware of any. It's only been—that's right, that's the thing that Dr. Randolph points to, that whenever there has been any evidence of waste and abuse it's generally on the vendor side, in Medicaid, where we've had studies it's been the doctors or the providers and not the poor.

And I obviously do not think that the poor should be penalized because of what the vendors do. But that gets back to oversight and implementation and careful targeting and monitoring, which we favor again. But the recipients should not be punished because of the provider problem.

Chairman LELAND. If the gentleman will yield on that point.

Mr. FAZIO. I'd be happy to.

Chairman LELAND. I remember when I was in the State legislature the question kept coming up about program abuse and we did look at the vendors, at least on the State level.

We found additional problems with excessive monitoring of vendors. With this monitoring comes greater administrative cost. As a result, suddenly you're taking moneys to use for monitoring that could go to services.

Does that represent a real problem in programs like WIC?

Mrs. EDELMAN. It is not—again, Dr. Randolph might speak to that.

Dr. RANDOLPH. I don't think it's a major problem, but I think that it has been a problem. I think that one of the difficulties is that a problem can surface and kind of run off very quickly in terms of inappropriate vendors. There is a need to have that oversight but it shouldn't be to the detriment of the program in terms of the dollars available for the actual services to be provided.

WIC, in terms of its administrative costs has a reasonable allocation of dollars.

Chairman LELAND. Now, you've made references to California and to New York and to Texas. We've not heard anything about Oregon.

Mrs. EDELMAN. Oh, I'll just turn to Oregon.

Chairman LELAND. I'd just like to yield the floor to the gentleman from Oregon.

Mr. SMITH. Thank you, Mr. Chairman. I, in fact, was just going over the Oregon numbers. Compared to the populations of New York and California—huge numbers problems. But we're not doing so well either on numbers for women of all races.

I just want to comment on the chairman's statement. I suppose all legislatures have gone through this oversight control kind of thing when there are mixes of Federal moneys. In Oregon we have done that several times. In fact, Governor Reagan came to Oregon and took our welfare system basically and—and I don't know what ever happened to it after that, but we—I think it's much the State's responsibility to keep tabs on these moneys, and we do that in Oregon, and to some success.

We even hired Touche Ross one time for about $60,000 and they visited the recipients and came back with a report that we ended up cancelling the legislation which tightened up the eligibility for receiving funds and saved the State $20 million. But it was at a State level and much of this oversight I think ought to be done from there.

I'd be happy with your leadership to encourage my State not only to improve the WIC Programs, but if you have any specific thoughts about the—program, I would be happy to take those back directly.

Ms. JOHNSON. Again, Oregon is a State where prenatal care has been intensively studied. You have some very good State public health officials who have looked into the problem of early access to prenatal care. *Financial barriers in Oregon* were found to be significant for many women.

You also have an issue of out of hosiptal births in Oregon that is rivaled only by that of Texas. So, Oregon is another State where we would very much like to see Medicaid eligibility levels for pregnant women and infants expanded at State option.

Mrs. **EDELMAN**. Maybe we could write you a letter and the Oregon delegation can get on your State officials——

Mr. **SMITH**. I would appreciate that. If you write it to me, I'll get it to the rest of them.

Ms. **JOHNSON**. We'd be delighted to do that.

Mrs. **EDELMAN**. Can I just brag on Mississippi?

Chairman **LELAND**. Well, let me——

Mrs. **EDELMAN**. This poor, struggling State that's doing better on WIC.

Chairman **LELAND**. Well, I'm glad to hear that because we're very happy that we've been joined not only in this committee but in the Congress by a person who really does care about what's happening, particularly in the impoverished community that he serves—the Mississippi Delta.

The committee's first field hearing, as a matter of fact, went to the Mississippi Delta and we saw the horrors of poverty there first hand.

Let me also make a very careful note that we have also additional influence in the State because the chairman of our Appropriations Committee is also from Mississippi. Therefore, we ought to be able to really solve some of these very serious problems. We don't have the kind of influence that Mississippi has.

But I know that the chairman has expressed a desire to do even more about the problems there. But given all of that and the pride that you have exhibited just by your hint, let me now yield to the gentleman from Mississippi, Mr. Espy, our new member.

Mr. **ESPY**. Thank you, Mr. Chairman. And let me apologize for coming in rather tardy. You know, we have roll call votes and all these things and particularly freshman members have to——

Chairman **LELAND**. Showing up was everything. [Laughter.]

Mr. **ESPY**. Let me also add that when the committee came to Mississippi I was not a Member of Congress at that time. I did come in late, perhaps my question is one that has been covered. If so, I apologize.

I was reading in the Sunday magazine of the Washington Post recently an issue on infant mortality, the cover read, "Infant Mortality in the District" and what the District can learn from Mississippi. I read the article with great care, and I was pleased to learn that although infant mortality around the Nation, and Mississippi in particular is entirely too high, we have done some things right. I now think we have 1 out of every 66 babies die in Mississippi before they reach age 1.

I'm all about forecasting and amplifying positive aspects of Mississippi and things that we are doing right. So could you amplify on that for me, the infant mortality subject?

Mrs. **EDELMAN**. Well, Mississippi—I guess with the leadership southern Governors and Governor Riley, particularly former Governor Riley from South Carolina have been providing—the South recognized and the poor States in the South recognized that they had a special problem in infant mortality. They really went about trying to provide some leadership in the last *3 to 4 years. I think* it's been because of that leadership that a number of very poor southern States that had to work a disproportionate problem really began to try to put into place the kinds of policies that would begin to turn this around.

Now, they've got a long way to go. I was just looking at Mississippi compared to, say, the States with 30 and 40 percent participation rates, and New York State is now 45 percent. Mississippi's participation in WIC is now at 57 percent. And again, for poor States, that's very good.

That is not to say you don't have a long way to go. Second, the point of that Washington Post story, one that embarasses me deeply, is that our Nation's Capital where we all sit, and which should be a symbol of America, tends to lead the Nation continuously in infant mortality. A baby within a few blocks of this hearing room is more likely to die in the first year of life than a baby in Trinidad or Tobago or in Costa Rica, and that's just a disgrace.

We are consistently lagging behind the rest of the Nation in access to prenatal care, in low-birthweight babies, in teen pregnancy rates among black young people. And again, you know, there are things that can be done that have not been put into place in this, our Nation's Capital.

We wanted hopefully, since the mayor came from Mississippi, to show him that we would hope that he might take advantage of his old State in his new found role and some of the lessons that they are trying to put into place. We do hope—we are meeting with him next week—and we do hope that we can begin to get him to commit to the kinds of leadership that is beginning to take place in a place like Mississippi.

Now, that's not to say that you're perfect, and we've got a long way to go in seeing that every mother gets access to adequate care, but at least the kind of outreach, the kind of public health centers, the networks in your various counties are things that we would like to have in our capital neighborhoods.

I do hope within the next few years we can turn our Nation's Capital into a model for all of you to take back home in terms of what ought to be provided, in terms of access, and in terms of WIC participation and in terms of a public system of care. At the moment, our Nation's Capital does not have a system of care for poor mothers and children in this town and we really do have to see that that occurs.

Ms. JOHNSON. The Mississippi legislature has voted funding to take advantage of last year's Medicaid expansions. They were the first State in the Nation to do that.

Mrs. EDELMAN. They are poor, and again that gets back to leadership. I would never have thought that Bill Elain, who used to be one of my least favorite opposing attorneys during my years as a practicing lawyer in Mississippi, would come around and is at least trying to provide that kind of leadership. I would think that all of your Governors would like to do at least what Mississippi can do.

In fact, we set up Mississippi to say if Mississippi can do it, anybody can do it. I would just hope that the rest of the Nation can now catch up with poor old Mississippi in providing for poor mothers and babies.

Chairman **Leland**. Don't get too anxious to leave. We've touched on the problems of teenage pregnancy. Dr. Randolph, don't feel slighted. I want you to jump in wherever you have input. I'm concerned about teenage pregnancy and I know how it contributes to the problem of infant mortality.

What can Congress do to help with campaigns for prevention?

Mrs. **Edelman**. Well, there are a number of things the Congress can do. The first thing is that Congress can begin to educate itself about what is a complex problem. One of the things I worry a lot about is that we're now beginning to redefine the teenage pregnancy problem as a complex issue of positive life options and which needs a comprehensive approach, a collaborate approach with a partnership between government, the communities, and the private sector. So, we need to sort of see this as a problem that the Nation can solve, which is going to take us 5 to 10 years. It's going to take some significant investment and that's important.

There are a number of ways in which Congress can act. One is the single most important beginning step you can take, chapter 1 is up for reauthorization this year. We now know that young women with weak basic skills are six times more likely to get pregnant while they are teens than young women with average basic skills.

We know the chapter 1 now works to teach kids to helping disadvantaged kids catch up with more advantaged kids in reading and math. The most important thing we can do to prevent teen pregnancy is to deal with just helping kids learn good reading, writing, and computing.

Again like with WIC where we are saying let's set a goal, Congress, that by 1992 every eligible child and mother will be covered by WIC. In the committee, with Chairman Gus Hawkins, where I'm heading right after this hearing, we've gotten the full funding recommitment to say by 1992. Within the next 5 years, every eligible child for chapter I will get it because we know it works in remediation and how can we afford not to provide it. Yet, only 50 percent of our kids now get it.

In a number of these preventive programs where we know they work, we cannot afford not to do it. Bolstering basic skills is one. Second, bolstering the sense of hope and involvement of young people at work. Summer jobs programs, Job Corps, and we've got some provisions for creating some new community learning centers because the entire community needs to be involved in learning and reaching out and role modeling. Every community center everywhere, churches and synogogues should be involved in trying to reinvolve themselves and kids in a learning process. We'd like to see something called community learning centers funded so we can again bolster that hope and literacy building among all of our young people.

Third, we'd like to see something called youth opportunity accounts. While we have had an investment in our Nation for young people who are going to go onto college, for those young people who are not going to go onto college there should be some kind of incentives to go into good vocational tracks or into some kind of jobs. So we are testifying before Congressman Hawkins' committee about the need to try to talk about some youth opportunity accounts for young people who stay in school, who engage in community service, so that they will have a place to go with some kind of support from the private sector and the public sector.

The kind of Boston partnership and the kind of thing that Eugene Lang is doing that seems to bolster hopes of young people staying in school. That strategy needs to be broadened, and I think that we'd like to see it tried through targeted investment to see if we can't have that happen in more communities.

Four, you've got to provide good health care. By providing comprehensive coverage, you've got to pick up a lot of these teens who are medically underserved group of young people. We hope through the Maternal and Child Health Block Grant Program that we can begin to focus more attention on schoolage children for whom we often do a very bad job at health departments.

I hope we can get the money through the supplemental appropration, not only in the House. We are hoping that we can get $75 million more in the Maternal and Child Health Block Grant Program where we can begin to focus more attention because, again, we are doing too little too late. If we can start dealing with young people and their health care needs all along the course of development, it would be important.

Getting the kind of access that you are talking about to Medicaid and to the Maternal and Child Health Block Grant Program with targeted programs for teens and for school aged kids would be an important step.

Nutritional help, again, is always important. I mean, children should not be hungry. Hungry children don't do well before they reach school, and they don't do well in school. So the nutrition and health components should just not be under discussion. Every child should have that.

Last, investing in early education and seeing that every child receives this important services. We're serving only 18 percent of the eligible children in Head Start. How can we afford that? While we're talking about bolstering basic skills, you can't start just at 6 years old. We've got to see that the babies of the teen mothers get that nutrition, get that prenatal care, that that mother prevents that second baby, and that the babies get into some early childhood stimulation programs. So that by the time they reach first grade they are not already behind.

We've got to talk about a continuum of investment from birth on in all of these children, but with a focus on prevention, which we simply don't have.

Chairman LELAND. You've just answered my follow-up question that is, What do we do with the babies who are born of babies?

Mrs. EDELMAN. Well, we've got to make sure the both of them have opportunities to develop.

Chairman LELAND. Is it not true that most teenage pregnant girls—and maybe this is not a fact, but you tell me what the facts are—create a cycle; is that not correct? When teenage girls have babies, their babies are more likely to have babies in the long term because of the cycle?

Mrs. EDELMAN. It's called poverty. Eighty percent of mothers 25 and under who have a child are living in poverty. If we want to break into the cycle of poverty. We have got to prevent teen pregnancy.

Too little attention is paid in the country to the relationship between young workers and low wages. Even two parent families who were teenagers who married, can hardly make a living that will bring those children out of poverty because of the minimum wage, because those young people who tend to get pregnant or to become fathers too early tend to be school dropouts, or those who don't have the skills to get the decent jobs to support families.

We have a major, major crisis in trying to talk about delay because the real consequence of early pregnancy and early marriage for both boys snd girls is poverty, because: they cannot get a job; they cannot earn a decent wage; they cannot support a family.

Second, we have got to deal with the already existing population of teen mothers who have children, and plan policies that will bolster both the baby and the 15-year-old mother, 16-year-old mother. We've got to try to get that mother into the health care system so that she does not have that second child within 2 years of their first baby.

Then we have to talk about the roles of the schools in a way which we never have because how do we keep that mother in school so that she: One, doesn't have a second baby and, two, can get that high school diploma and hopefully can prevent welfare dependency.

It's critically important to examine how we get the baby in a position where the baby can begin to function and get the early investment that will translate, by the time she's 6, into doing well in school. We really do have to talk about a continuum of services for both generations of children if we're going to break this cycle.

So the notion of prevention, the basic role of schooling and supportive services that allow those mothers to stay in school, and child care are important pieces of that.

Let me just emphasize——

Chairman **Leland**. Is this a function or responsibility of our public schools, too?

Mrs. **Edelman**. It's not only a function of our public schools, but everybody. We've got to talk about a variety of child care settings. One of the big issues in this current welfare debate is we think we can do cheap child care or do child care on the cheap. If we're serious about getting young babies up to the point where they can do well in school and pull their own and not be prey to pregnancy again in a second generation cycle or school dropout, then we should be investing every extra dime we can find in good child care.

Child care for both the mother and the baby, and it should be comprehensive child care, is critically important. The Congress just has to think about what is it we're trying to accomplish. If we're trying to break into this every generational poverty cycle and prevent an underclass, then one has to talk about really good child care and prevention policies for both that mother and baby.

Chairman **Leland**. Dr. Randolph. Let me apologize to our other panelists. We want to give you equal time.

Dr. **Randolph**. Just a couple of comments. I think Marian has been very eloquent. One of the statements that has stuck in my mind in the document Risking the Futures is people's understanding of one of the essential issues relative to prevention. If you could state it in one sentence, a very complex issue, it would be that an objective is to postpone the first pregnancy beyond the year 18 and the receipt of a high school diploma.

Second, in focusing the services we do talk a lot about the woman and the child. There is a male involved. We must strengthen the service capacity addressing males.

I think it's important also for the Congress to be aware of administrative prerogative—I'm sure you do understand the nuances of enactment of administrative regulations to accomplish things that perhaps the legislation didn't quite intend to allow to happen.

Chairman LELAND. Never presume the intelligence of the Congress.

Dr. RANDOLPH. I would suggest that there needs to be some inquiry into the title X administrative rules and regulations which apparently create a situation where programs providing those title X funded services will no longer be allowed to count the services that they are providing to males as a part of their service provision capacity. Therefore they would not get funding to support the provision of those services. And it seems to me that this is a catch 22 situation and something that people should be very concerned about.

Mr. FAZIO. Do you think it's a pro-family policy?

Dr. RANDOLPH. Should I answer?

Mr. FAZIO. Yes.

Dr. RANDOLPH. I do not think it is.

Mr. FAZIO. I don't either, and I'm glad that you put it the way you did.

Mr. ESPY. Mr. Chairman.

Chairman LELAND. Mr. Espy.

Mr. ESPY. This month in Mississippi I plan to deliver approximately 40 high school speeches.

We're talking about Federal programs, and certainly I'm all for programs that can alleviate poverty and infant mortality. But there are a number of things that the child or the teenager can do himself or herself.

In my messages this month to schoolchildren, what would you have me say to the teenagers? What one or two things could I say that would weigh on their minds that——

Mrs. EDELMAN. There are a couple of things. One is: There are consequences, that sex is not without cost. I think that one of the things that we have had in our culture is this bombardment of young people that says sex is bliss without consequence and do it, do it, do it. You know, for young women it means they're going to be grounded for an awfully long time. For young men it means that they may well now find that the responsibilities of fatherhood will be imposed. I hope we can get a child support system that will begin to work for both of those young people.

The consequences of too early sexual activity are great both in terms of venereal diseases—because teens are at greater risk of that—in terms of producing babies who have deficits and defects and they wouldn't want to put on another generation. They need to be forced to think through the consequences of too early sexual activity.

Second, they ought to understand that they won't have a better life than their parents had, to understand the relationship between these kinds of things and poverty. And, third, they need to understand the importance of family to the strength of the black community, to the community generally and to the future of this Nation that they have a role in contributing to that.

I think they need the sense that they could, as you know, be anybody. I think adults need to reinvolve themselves in giving young people hope and giving them a sense of what the future can be and who they can be in the future. That's critically important.

I want to just reemphasize what Dr. Randolph has said, that we need to get parents and schools and everybody else talking to our boys as well as our girls because we wink at our boys and we tell our girls to stay chaste. This double standard in this Nation needs to stop. As much programming needs to be focused on boys and girls.

Third, you need to get at the parents and you need to get to the adults in the community to say that they need to be better examples because children do what we do, and not what we tell them to do. The fact is that two-thirds of all out of wedlock births in our Nation are to adult women. They were impregnated by a whole lot of adult men.

What is not glamorous for Farrah Faucett and for Sam Shephard should not be subject to those double standards. I think we need to tell adults that the teenage sexuality problem is an adult sexuality problem. We need to be better morally and we need to reinvolve ourselves more in our churches and synagogues, in reaching out to young people because things weren't easy when we were coming up either. Except that then the adults paid a lot of attention, spent time with us, had programs and churches and schools, and had high expectations. We need to redo that. I don't need to tell you what your speech is, but obviously I'd love to have a copy of it so that we can spread it around elsewhere.

Chairman LELAND. Very good. We've been joined by the gentleman from New York, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. I'm sorry that I had to be down at a State conference at the White House—important issue these days. Mr. Chairman, I want to commend you for holding this important hearing.

In the last 5 years our Nation's world ranking in preventing infant deaths dropped from 16th to the 18th place and clearly hunger plays a major role in this. And we recognize that something critical has to be done.

The link between low birthweight children and infant mortality and inadequate diet certainly has been well documented, and we welcome having our experts before us. I want to join our colleagues in welcoming these experts today and the other panels that we're about to hear from.

We would welcome any constructive ideas. I would like to pose a question to Dr. Randolph. I'm certainly very much impressed with the commitment of our own State, New York State, to provide comprehensive prenatal care to low-income women who are unserved by the Federal-State cooperative programs.

From your position, Dr. Randolph, as a health administrator, what areas are there to improving coordination between the USDA and HHS funded programs?

Dr. RANDOLPH. I think the perception of barriers is different depending upon where you sit. I get the impression that at the State level there may not be on an operational basis as many barriers to communication and to attempting to address some of the issues.

One of the things that we have been undertaking in New York State is to look at our WIC population, for an example, and attempt to look at what other food programs those individuals would, in fact, be eligible for, could take advantage of, but have not for some reason been able to access.

We're in the process of reviewing much of that information. This was alluded to earlier to the extent that there are different eligibility requirements across programs. It becomes the morass in terms of determining which subset of the population in one program is eligible for another program.

And in addition to that, I think that to the extent possible there should be an upfront opportunity to do some joint planning around what ought to happen relative to an entire group or sets of populations. Often times that doesn't happen.

In other words, the different funding streams have their own requirements and they don't really allow for an opportunity of interaction and coordination.

So I would call for a stronger role federally in coordination of those programs and then we, at the State level, can also serve as the barometer in terms of where that breaks down.

Mr. GILMAN. Are you called upon on occasion to make some input on policy at Federal level? Are there any policy conferences where State administrators are brought in?

Dr. RANDOLPH. Yes, there are. But in general a lot of that discussion is through the Public Health Service and the Bureau of Maternal and Child Health. The extent to which there is cross agency communication with input and policy, I think could be strengthened.

Mr. GILMAN. Do you have an opportunity to make your constructive suggestions to policy people at the Federal level?

Dr. RANDOLPH. I will say that we make it our business.

Mr. GILMAN. Good for you. Do you find enough outreach in the programs so that people out there are familiar with what's available? We found that when our committee went to some of our service areas, social service areas, that this was one of the big complaints, that there wasn't enough outreach.

Dr. RANDOLPH. I would agree. I think there is insufficient outreach and I also think that there is often times inappropriate outreach. Taking into consideration, I have an example in New York where we have a significant population that comes from the Caribbean.

One of the things that we found out was that to do appropriate outreach might mean, in fact, that we had to put some of our advertisements not in the newspapers in New York, but in the newspapers in the home country because those were the newspapers that many individuals read when they were in New York.

And so, having an opportunity to really understand the culture, the daily living situations, the value systems of the populations that we're trying to serve is equally important in terms of trying to construct appropriate outreach.

Mr. GILMAN. Thank you. Thank you, Mr. Chairman. I see we have a vote.

Chairman LELAND. Let me just thank the panelists for their participation. You've been great. Let me beg your indulgence to have other questions that we'd like to submit to you in correspondence. If you will please respond we'll make those responses a part of the record.

Thank you so much. You've been great. The Chair is going to suspend the hearing until such time that it takes us to go vote and return.

Prior to my doing that, however, I would like to refer to a study that was sponsored by Mayor Raymond Flynn. I alluded to it earlier. Without objection, I ask that this study entitled, The American Crisis of Infant Mortality, Issues and Recommendations, be admitted into the record.

Thank you and we'll be back in just a few minutes.

[The study referred to above appears at the conclusion of the hearing, see p. 134.]

[Recess taken.]

Chairman LELAND. Let me again apologize for the interruption. As you know, our primary responsibility as legislators in the Congress of the United States is to tend to the business at hand, particularly when we have votes on the floor. We will, I'm sure, from time to time be interrupted before these proceedings are over.

We'll now hear from Dr. J. Michael McGinnis. Dr. McGinnis is a Deputy Assistant Secretary for Health and serves as the Assistant Surgeon General. He is also the Director of the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services.

Dr. McGinnis is accompanied this morning by Dr. Vincent Hutchins, the Director of the Division of Maternal and Child Health. It is indeed a pleasure to have both of you with us. We'll just ask you to proceed as you see fit.

Dr. MCGINNIS. Thank you very much, Mr. Chairman.

STATEMENT OF J. MICHAEL McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY VINCE HUTCHINS, M.D., DIRECTOR, DIVISION OF MATERNAL AND CHILD HEALTH, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Dr. MCGINNIS. Mr. Chairman, it is a privilege to appear before you and to talk a little bit about our departmental initiatives in maternal and child health and with a particular emphasis in the nutrition aspect.

I have a formal prepared testimony which I'd like to submit for the record, if I may.

Chairman LELAND. Without objection, the full text of your statement this morning will be entered into the record.

Dr. McGINNIS. Thank you.

Chairman LELAND. We appreciate the summarization of your testimony.

Dr. McGINNIS. Good. That's what I'd like to do is proceed with a summary from notes. And I'd like to begin by noting, in effect, my bottomline, which is that the death of any infant in this country is not only a personal tragedy but a national loss.

Each year, in spite of that fact, about 40,000 infants have died before reaching their first birthdays. And I think that that fact is even more onerous to the Nation when you consider that the people who are the victims of these problems are those in the most vulnerable segments of our society.

We have made substantial progress that you've pointed out and other members of the committee have pointed out. I'd like to just touch briefly on a few of the highlights in that respect.

There is some good news and it's important to acknowledge. In 1900, nearly 10 percent of all babies died before they were 1. Now the figure is only about 1 percent; this is substantial progress. In the last decade alone, the Nation's infant mortality rate has declined by about 30 percent, which again is substantial progress.

For Native Americans the decline is even more impressive; about 31 percent over the last 7 years. In addition, our Nation has the best record throughout the world in saving the lives of very small babies. That's also important to point out.

Nonetheless, in spite of this progress we're beset by serious problems, again some of which have been pointed out by members of the committee, and I'd like to touch upon those which are particularly important.

At the top of the list is the fact that the rate of black infant deaths remain double for that of whites. About 7 percent of our babies are still low birthweight and therefore at a particularly high risk. And there's been only a nominal improvement in that issue over the last decade.

A rate of progress against infant mortality has begun to slow in recent years, basically dropping to around a little under a 2-percent decline per year over the last 3 years, which is lower than the 4 percent average per year decline that we saw in the late seventies and early eighties. And, as has been noted, we rank well below a number of other countries in terms of our position globally with respect to infant mortality rates.

These problems collectively suggest that we may fall short of several of the national goals that we established to be achieved for infant health throughout the decade of the eighties.

Our midcourse assessment of that progress, which was recently published in this volume, taking a snapshot of the picture in 1985, the midpoint between the decade from 1980 to 1990, indicates that of the 19 objectives in infant health, about four are on track to accomplishment, about 11 are unlikely to be achieved because of the problems mentioned, and four have insufficient data to tell at this point how we're going to do over the longer run.

Some of those objectives that we're most concerned about include the target that by 1990 no county and no racial or ethnic group should have an infant mortality rate greater than 12 deaths per 1,000 live births. Yet, for example, black infant mortality rate in 1984 was 18.4, substantially above that. We're not going to meet that target.

The target that low birthweight not exceed 5 percent of live births by 1990, and yet in 1984 about 6.7 percent of babies born were of low birthweight. And, as I mentioned earlier, the rate of decline indicates that we're not going to meet the target by 1990 and this is largely because the low birthweight rate among black babies is up around 12.5 percent.

We're not likely to reach the target that growth retardation caused by inadequate diets be eliminated in the United States by 1990. The range in 1983 was from 11 to 24 percent depending upon the studies involved and the groups of individuals that were focused on.

In addition, we're not likely to meet the target that by 1990 at least 90 percent of pregnant women from any ethnic group get prenatal care in the first trimester. In 1984, about 20 percent of whites were not getting prenatal care in the first trimester and 38 percent of both blacks and Hispanics were not getting prenatal care in the first trimester.

These are all problems that need to be addressed and addressed aggressively in the course of our national efforts to improve our infant mortality profile.

Discerning the source of the problems is one of the greatest challenges to comtemporary health policy. We know that the dominant contributor to the—is our preponderance of low birthweight babies, and we also know that certain risk factors predispose to low birthweight babies; physiological factors, social and behavioral risk factors, dietary risk factors.

The physiologic risk factors include low prepregnancy weights, they include illnesses like diabetes and some GI disturbances, high blood pressure, toxemia, and so forth.

The social and behavioral risk factors include prominently income levels and educational levels of the mother, the access, as I mentioned, to early prenatal care, marital status, youth, use of drugs, alcohol, and cigarettes during pregnancy; all important determinants in low birthweight outcomes.

Dietary factors that are relevant and important risk factors in low birthweight include inadequate weight gain during pregnancy, often due to inadequate protein and caloric intake, or insufficient nutrients like iron, folate, zinc, and calcium.

To correct the problem we need to work on all fronts. We need to get pregnant women into early care, we need to motivate healthy practices and behaviors relevant to healthy pregnancy outcomes. We need to improve diets. Most of all we need to reach those who are now hardest to reach and most vulnerable for these problems.

Our basic efforts in the Department of Health and Human Services to address these issues are housed in the Medicaid Program and in the Maternal and Child Health Block Grant Program and the Public Health Service. In addition, several recent developments we hope will be helpful in this respect.

The expansion of the Medicaid eligibility for pregnant women and children to remove certain barriers to participation has already been referenced here in the committee, and we anticipate this will help with the progress.

Another that hasn't been discussed is the Secretary's initiative currently in development and soon to be announced for the provision of case managed comprehensive services, including medical, nutritional, and educational services to those at particularly high risk. This will be run through a special demonstration program under Medicaid and will focus again on reaching those who are currently disenfranchised from our society.

Others include a special low birthweight prevention work group that's cochaired by Dr. Hutchins here and the Director of the National Institute for Child Health and Human Development; special project grants funded by the Maternal and Child Health Program focused on target groups in improving services delivery; the work of the National Health Service Corp in ensuring that obstetricians and gynocologists and pediatricians are provided to areas that currently haven't adequate coverage by health providers; the work of the community health centers and migrant health center programs; the work of the Indian Health Service to ensure that a regionalized system of perinatal care is provided for their client populations; the work of the Centers for Disease Control in establishing a severe pediatric malnutrition study that looks at the feasibility of using hospital-based data to identify pockets of potential undernutritioned among vulnerable groups; the adolescent pregnancy initiative, again targeting a problem that's been mentioned several times today; and the work of the family support administration in focusing in on insuring the integrity of the family unit as a contributor to reducing infant mortality.

In addition to these programs that we conduct within our own Department, we have several special cooperative efforts related to the WIC Program that's run by USDA. These efforts are important to ensure that at every level we do have at the Federal level a series of regular staff meetings to ensure policy coordination. We have two representatives from our Maternal and Child Health Program on the WIC advisory board.

We have a formal joint USDA-DHHS group which develops cooperatively and approves cooperatively publications that relate to maternal and child health nutrition, to ensure consistency between the two departments in that respect.

The Department of Agriculture is supporting the National Center for Health Statistics conduct next year of the National Maternal and Infant Health survey to pinpoint elements of special risk for infant death. We have a joint effort with USDA and Nutrition Monitoring again to give us an early indication of where problems might be developing. And there are joint cooperative agreements with—between USDA and the Centers for Disease Control to look at the relationship between infant mortality and a variety of issues, including smoking cessation, adequate nutrition and so forth.

In sum, Mr. Chairman, there really can be no more compelling priority for the Department of Health and Human Services than the topic of today's hearing. We are grateful for your interest and appreciate the opportunity to discuss it with you.

Thank you.

Chairman LELAND. I thank you very much for your testimony.

[The prepared statement of Dr. McGinnis appears at the conclusion of the hearing, see p. 99.]

Chairman LELAND. Dr. McGinnis, in your testimony you state that the provisional infant mortality rate for 1983 to 1986 indicates a slowdown in the rate of decline and that the September to November 1986 data revealed no further decline.

What factors are responsible for this serious regression?

Dr. MCGINNIS. Well, it's difficult to say precisely what factors are, but I think that one of the major factors is that some of the progress that's been made to date, and it's been substantial over the course of the last 15 years or so, has been achieved in many respects among those who are easiest to reach.

We're now facing the hard core problem areas and it's important for us to take special measures to reach out, to identify those who are at special risk, those who are more socially isolated than others.

Hence, the reason for the Secretary's initiative proposal.

Chairman LELAND. I am aware that representatives from USDA and HHS have worked together to study the need for improving the coordination between the MCH and WIC Programs.

Please, if you can, summarize the major findings of the study and explain how HHS plans to ensure implementation of any recommendations at the Federal level.

Dr. MCGINNIS. Well, I think the major findings of the study focused principally on the need to ensure a close communication at every level of WIC administration and MCH administration to the Federal level, the State level, and the local level.

In addition, it identified special needs to ensure that the differences in eligibility criteria were addressed to the extent possible, even though the two programs are completely different programs, to ensure that facilities were shared and resources were shared wherever practical; and to ensure that any complexities in financial administration that served as a barriers to entry and coordination were dealt with.

We are taking steps in several ways to try to address these problems. First, as I mentioned, we have regular meetings at the staff level between the MCH staff and the WIC staff to ensure their coordination. We've identified liaisons at the regional level.

The Department of Agriculture is identified as a specific liaison, we have identified a specific liaison to ensure a close coordination at that level. We've tried to work to ensure that at the State level there is joint administration of the WIC Program and title V, because, after all, that's where the real action takes place. And without that kind of cooperation, the overall level of communication is going to be damaged.

We've tried to work with WIC to ensure that WIC does not place their programs in a nonhealth setting. For a period there was a time in which that was beginning to crop up as a problem, but we are confident that that will not be a problem in the future. Of course there needs to be a very close association between these two efforts.

And we've developed to get collectively a joint nutrition monitoring system to ensure collaboration between the two.

Let me ask, if I may, Dr. Hutchins if he has any elaboration on that point.

Dr. HUTCHINS. I think that covers most of it. We also have worked with leadership of the association of MCH directors and the association of the WIC directors at the State level to encourage what has been an ongoing relationship between them.

And I think the only other thing is that there is a joint publication committee at the Federal level so that we are—to be sure that we're giving the same message to both providers and the people who are using the services.

Chairman LELAND. In view of language enacted in the Budget Reconciliation Act last year, what incentives are you providing the States to expand Medicaid coverage?

Dr. MCGINNIS. Let me ask Dr. Hutchins to respond to that.

Dr. HUTCHINS. We've worked with the Southern Governors Association for a number of years and the activities that Mrs. Edelman was talking about this morning. After the passage of the last ones we worked with the National Governors Association and they called a one day meeting in Washington about a month ago for people from the Medicaid side of the State and from the health side of the State and also from the Governors' offices. There were about 40 States represented at that on fairly short order.

We were encouraged, I think, by the amount of response that there was to that. We've continued to work separately with the association MCH directors, the Medicaid people and also with the National Governors Association to encourage that our latest reading, which is kind of anecdotal at this point, is that 10 to 20 States are probably going to adopt the options before the end of the fiscal year.

Chairman LELAND. The committee's recent report on hunger among the homeless identified high infant mortality and low prenatal care rates among homeless families.

What is HHS doing to bring comprehensive prenatal services to this very high risk group of people?

Dr. MCGINNIS. Well, again, the key here—you've pinpointed a good example of the precise issue that I was mentioning earlier. We are at a point where we need to take very special and indeed extraordinary measures to reach out to identify those who are most vulnerable. And that's one of the reasons of the secretary's initiative; to develop a solid outreach case management activities to ensure that those who are currently disenfranchised are brought into the system.

Chairman LELAND. Mr. Flake.

Mr. FLAKE. Yes. I've just completed, last week, a tour through the maternity ward at a hospital in Queens, N.Y., where I saw a number of babies incubators who are products of mothers who carry AIDS. I don't see this addressed in your particular statements today.

I just wondered if this is a growing problem and how the Department has determined it might be able to address it.

Dr. McGINNIS. It is a growing problem and it's a problem that we didn't address in this testimony because we weren't specifically asked to address it. But I'm happy to have the opportunity now.

We have quite a broad plan for control of the AIDS problem that's developed in the Department of Health and Human Services, indeed at the Federal level generally. And included in that plan is programs specifically targeted to mothers who are drug addicts and most at risk for carrying the AIDS virus and therefore most at risk for delivering babies who are exposed to the problem.

Last week the Surgeon General had a conference that addressed this issue specifically. We see it as now still a small problem, but one which is clearly going to grow because of the exposed population.

Dr. Hutchins, do you want to elaborate?

Dr. HUTCHINS. Only that the—I think it's our concern about what's going to happen. Most of the children, and there about by the CDC definition a little over 400 who have been identified thus far, 60 percent of whom have died. Most of them are in major cities and the largest percentage, as Dr. McGinnis has said, are with parents who are IV drug abusers or sexual partners of IV drug users.

We have a concern about how to care for them; part of it is foster care for those who are already infected. But I think the message that came out of the workshop was that the other States need to start planning for what is likely to come to them on the basis of experience that New York, New Jersey, California, Florida have had so that they won't be surprised by what is happening as the other States were.

So I think it's a major task that is before us. The report of the Surgeon General's workshop should be available in a couple of months and I think will be helpful to other segments of the public society that need to work on them.

Mr. FLAKE. Now, the mortality rate of those children is currently at about 60 percent by your estimate. I that a——

Dr. HUTCHINS. Well, those that have been identified in the last few years about 60 percent have died. A more, a larger and the projection is that the number of pediatric AIDS cases will be around 3,000 in 1991. That's not to talk about the number of adolescents who are included and the adults because the definition is being used of those under 13.

I think another concern of ours is that we're starting to hear of positive cord—positive for HIV virus that are coming from some of our large cities and particularly in New York, and what the implication that's going to have.

Mr. FLAKE. Another related issue having to do with this issue, from talking to hospital administration, is the number of nurses not wanting to take part in caring for those particular babies with AIDS.

Is there something you can identify that will allow us to increase the probability of those children surviving by ensuring that there are people there who are willing to take the risks involved in caring for those babies?

Dr. HUTCHINS. That is a major problem that we have. And as Dr. Koop has been telling us, we need to do a lot of education of both the general population as well as the providers and the schools that are trained for inservice education that needs to go along.

In talking to Dr. Heagarty from Harlem Hospital just on this issue at the conference, she was very concerned about that and felt that they had over the last couple of years been able to help staff accept the fact that one could work with these children in a supportive role and with their families, but that it takes a certain amount of ongoing inservice and a diminution, if you will, of the kind of panic reaction that we sometimes see happening around.

Those are particularly the issues that will be a—that places have not been affected yet need to know and be prepared for it rather than, as Dr. Heagarty has said, it took them a couple of years to get staff ready for it when the problem was already upon them.

Mr. FLAKE. And though you may not be the agency to really address the question, is it possible to set up some regional or other type of training centers for staff persons in an area where AIDS I think we all would agree is becoming of epidemic proportions?

Is that a realistic possibility for at least trying to address the problem as it relates to infant care?

Dr. HUTCHINS. I think that all of us that have some responsibility for these populations and whatever it is, whether we're coming from the health or the social service or the education side, have to combine our resources to do these activities that are necessary.

Dr. McGINNIS. Now, in fact, the health resources and services administration is setting up some educational training centers specifically focused on providing information to health care providers.

It's important to emphasize I think as well that the health providers really are not at risk, that this is a myth. We have obviously with some 30 to 35,000 cases now of AIDS around the country, we have a considerable body of experience with exposure of health care providers to the AIDS victims and indirectly to the AIDS virus. And not one of those health care providers has come down or has even seroconverted.

So there really is no danger at all, even with the direct exposure like a needle stick from an HIV positive individual the risk is quite low. It's about 1 percent of the risk transmitting the Hepatitis B virus via a needle stick, for example. So it's education that's key here and prevention, of course.

Chairman LELAND. Let me just add for the purpose of the record that some 80 to 90 percent of all children affected by AIDS or afflicted with AIDS are minority children.

Let me yield now to the gentleman from North Dakota.

Mr. DORGAN. Thank you, Mr. Chairman. Dr. McGinnis, I'd like to ask about the availability of the WIC Program to serve the prenatal needs of the women in this country.

Do you have statistics with you today to indicate the coverage of the WIC Program at the present time? And if we were to devote the resources that we could devote to the WIC Program, and probably should devote to it, what kind of coverage could we get?

Dr. McGINNIS. Since we don't administer the WIC Program, I'd like to, if I may, reserve the right to provide those figures from the Department of Agriculture. I will say that the estimates that I have to date indicate that roughly 40 percent of those eligible for WIC are covered, are receiving coverage, that around 50 percent of pregnant women who are eligible are receiving the service. And around two-thirds of the eligible infants and around 33 percent of the eligible children.

But I'd like to check that. And what I'd like to add, though, is the point that is—is building on the point that you inferred, and that is that the key relevance of WIC for the overall effort to reduce infant mortality lies in ensuring that those linkages between WIC and the health care system are well established and that they are used to help reach out to the vulnerable population to get them into early prenatal care. And that's what we'd like to provide an even greater focus on in the future.

Mr. DORGAN. Now, I understand that the statistics from the first half the the 1980's demonstrate that a decreasing percentage of women in our country are receiving prenatal care.

If those numbers are accurate, what has caused that trend?

Dr. MCGINNIS. Well, I don't think that it's necessarily a decreasing percentage. The trend throughout the eighties has been, I think, a general improvement, although the problem is it's not an improvement of the magnitude that we'd like to see. We are, in essence, still in the water, so to speak. We're not making the kind of inroads against that that we'd like to.

Dr. Hutchins, would you mind elaborating on that?

Dr. HUTCHINS. I think that the number of women coming for prenatal care has leveled, those entering the first trimester have leveled off rather than going down. But that is one of the concerns, I think. So outreach of these populations, as has been mentioned several times this morning, is very important.

Mr. DORGAN. And the Department itself, can you describe what you're doing in terms of that outreach? What kind of policies and programs do you have in place to reach out to provide prenatal care to low-income women?

Dr. MCGINNIS. Well, we have a series of special project, grant programs, called the SPRANS Program. It's administered along with the MCH effort that's built around that general concept.

In addition, the Secretary has proposed a special initiative which has not been formally announced as yet, but which will shortly be announced that's focused directly on the issue of reaching out to hard to reach populations through an intense case management system.

I think actually there is also more that we can do with USDA in that respect. I'd like to see us in a—and I'm sure that this will be the case, that the Secretary's initiative will include a joint effort with USDA to identify ways in which we can use the WIC Programs to reach those populations.

Mr. DORGAN. Is there not now a joint effort?

Dr. MCGINNIS. Yes, but not as a part of this specific initiative. And I think a concentrated effort can enhance our efforts.

Mr. DORGAN. Could you get back to the committee and give us some idea of what type of joint effort you'd like to see that would be more effective than the present efforts? I think that is important.

A joint effort with your Department and USDA I think could make the difference. Let me ask one further question.

Do you live in the Washington, D.C. area?

Dr. McGinnis. Yes.

Mr. Dorgan. You have perhaps seen the advertisements I recall that specifically are on Channel 4, Beautiful Babies Right From the Start.

Can you tell me how that's funded and whose program that is?

Dr. McGinnis. Well, let me mention that we're pleased to have played a role in that and it's a program in which Dr. Hutchins has been personally involved, and I'd like to ask him to address that.

Dr. Hutchins. It's a national network that was instrumental to begin with. The March of Dimes has been funding it and is actually implementing it locally, and Blue Cross/Blue Shield has been involved. And then they have made an effort to have other community support, but those are the three major founders of the program.

This is really a test area. If it seems to be successful after a couple of years, they'll expand it.

Mr. Dorgan. And have there been any results, any discernible results, at this point?

Dr. Hutchins. I don't think there's been any measurement of that yet, but that's built into the program.

Mr. Dorgan. My observation is that you cannot live in this area without being exposed to that message. The message seems quite clear and I think attractively presented.

Both the chairman and I have recently been in maternity wards ourselves for family reasons. Both of us are parents of relatively new babies. And so, at least I'm pretty attentive to those TV commercials. And I think that sort of thing is exactly what we need to do, to be reaching out to tell people out there, and particularly low income women, that if you're pregnant there are things that you can and must do to assure yourself of having a healthy child. And there are programs available to help.

So I want to commend you for whatever role you've played in that and hope that that's the kind of outreach that we can do all across this country. And, much more than that, it's my hope that when we in a policy making position visit WIC centers around the country some day we won't be told by people who administer the WIC centers that they have a waiting list. I really would hope that we can serve those who have needs because it's the finest program that we administer in the Federal Government in terms of what it provides back to us.

It gives the right kind of care, the right kind of health care, saves us an enormous amount of money, and produces healthy babies. So I hope some day we'll be in that position of not seeing waiting lists at WIC centers.

Chairman Leland. Dr. McGinnis, you heard Mrs. Edelman talk about the fact that Washington is somewhat a disgrace to this Nation because it is the Capital, and yet we have the highest infant mortality rate in the country.

What is it that we can do for the District of Columbia since it is, to some great extent, a ward of the Federal Government?

Dr. McGinnis. Well, I'm sensitive to that issue myself because I have two children who were born in the District of Columbia as well. I think again to extend what was mentioned earlier about the project that currently is underway.

What's needed in addition to raising people's awareness of the problems at hand and the ways to effect problems, is an effort to change the incentives, to change the incentives around individual decisions to get pregnant, individual decisions of how to behave once you're pregnant, individual decisions to seek out or respond to prenatal care, and that involves a comprehensive effort that includes the schools.

It was noted earlier that one of the most important things that we can do is to keep kids in school, to do everything we can to change the incentives in the schools to make sure they're getting that high school diploma, is one of the highest priorities of our kids. To change the peer influences in the school setting.

There seems to be a negative cycle of peer influence now that actually promotes on occasion adolescent pregnancy.

It includes, in addition, changing the community signals that are given, not just in the schools, but outside the schools with the churches, with voluntary organizations, like Boys Clubs and Girls Clubs and other associations that have a special access into kids who are making decisions about their behavior, and who are forming their attitudes about teenage pregnancy and so forth.

And using these community groups, these community incentives to help people find their way into a care program. An issue that was mentioned earlier and is also important in incentives relates to jobs, in ensuring that if, for some reason, an individual decides not to continue their schooling, that they do have access to a productive job situation that doesn't give them another incentive to divert their attention by pregnancy.

And again, there are lots of other economic incentives involved that need to be attended to. So the issue is a very complex one, but it really comes down to providing incentives around individual decisions on pregnancy, on how to behave once you're pregnant, and incentives to get care.

Vince, do you want to add to that?

Dr. HUTCHINS. I think that sums it up pretty well.

Chairman LELAND. Is there some means by which we can hone in on Washington, D.C. and try to do all those things here that you mentioned to solve this problem?

Should Congress appropriate a special amount of money for the District of Columbia to execute the kinds of ideas that you have put forth?

Dr. HUTCHINS. That's a very interesting suggestion. Over the years because of the concern with this problem, and you've been involved with some of it before, there have been various task forces put together by the mayor of what programs might be implemented to assist in this problem and actually how one can bring the various pieces of the society together, as Dr. McGinnis was just saying.

You have to have more than just the health department involved. You have to have the schools and the universities and the hospitals and probably corporate involvement in it.

I think that's one of the things that we're learning from the Southern Governors is that they started out with a coalition of Governors and then a coalition of the legislatures, and now they have a coalition of corporate entities within the South that are moving to a coalition of ecumenical. And it's only by those various segments of society working together that I think we can work together on this problem so that money alone won't do it. It certainly will help, but it may be that you need some of the other elements in it.

Dr. McGinnis. Now, if I could elaborate just briefly on that, I think that in so many of the cases with prevention programs, federalizing the effort really isn't the answer in many respects. There are things that the Federal Government can do and——

Chairman Leland. Well, the only reason I suggested that, is because or the difference is that the District of Columbia has a special relationship with the Federal Government with respect to the allocation of appropriations.

I'm not necessarily advocating that we federalize everything to the extent that we're trying to address the problem in the whole Nation. But here in the Capital where the problem is so visible, we should try to do something special. We do a lot of other things special for the District of Columbia because it is somewhat a ward of the Nation.

Representative Walter Fauntroy does not even have a vote in the Congress because of the fact that this is a special relationship. So I think that it is incumbent upon us to do certain things that are deemed special, and maybe this is one of them.

Let me thank both of you. I apologize for having to cut you short, but I've got to literally run for a vote. And I will apologize again to our next witness and ask all of you to please indulge me as I go vote and try to come back in time to adequately serve the interest of this committee hearing.

Thank you very much.

Dr. McGinnis. Thank you, Mr. Chairman.

[Recess taken.]

Chairman Leland. We will resume with Dr. Wise, if you will proceed. Dr. Wise is the director of Perinatal Epidemology of the Joint Program in Neonatology at Harvard Medical School; he is a fellow in the Division of Health Policy Research and Education at Harvard, and serves on the faculty of the university school of public health.

He is also a member of the Physicians' Task Force on Hunger in America. That task force has helped to illuminate the problem of hunger in America and heightened public interest in efforts to alleviate this condition.

We in this committee certainly appreciate what you have done. Dr. Wise, we are pleased to have you with us. You may now begin your testimony as you see fit.

STATEMENT OF PAUL H. WISE, M.D., DIRECTOR, PERINATAL EPIDEMIOLOGY, JOINT PROGRAM IN NEONATOLOGY, HARVARD MEDICAL SCHOOL

Dr. Wise. Thank you. I'm a great admirer of the work of this committee and certainly very grateful for the invitation to testify today.

As it was pointed out earlier today, the infant mortality rate in the United States has been reduced dramatically over the past two decades. In fact, from our looking throughout history, rarely has the mortality rate of any age group shown such significant improvement over such a relatively short period of time. This experience has been viewed widely as a major success, in fact, a testament to America's technical capacity and medical innovation.

However, it is my view that this recent period of progress in infant survival in the United States is entering a new phase of increased vulnerability, a period in which the role of nutrition programs for women and infants will take on added significance.

The importance of nutrition programs today is greater than the importance of nutrition programs five years ago to the infant mortality rate, in my view. Our work and the work of others have shown that the driving force behind recent reductions in infant mortality has been the improved survival of low birth weight babies, due primarily to the developments and clinical implementation of intensive medical technologies.

However, it seems clear that this dependency on medical progress will ultimately run its course. For as we improved our capacity to save smaller and smaller newborns, we have done little to reduce the rate at which these high risk babies are being born.

In addition, the mortality rate of all infants during the postneonatal period also remains high from 28 days to one year of age. We are fast reaching the limits of our technology to save extremely premature infants. It is therefore quite likely that the infant mortality rate will become increasingly dependent upon the postneonatal mortality rate and the birth rate of low weight babies.

Because these two persistent problems are closely related to alterations in social conditions, the adequacy of prenatal care and nutrition will convey to the infant mortality rate a heightened sensitivity to economic trends and levels of social funding.

It is not the failure of medical technology that brings us to this period of increased vulnerability. In fact, it is its success, in that it has left more glaring the yet unattended issues of low birth weight and postneonatal mortality; issues which relate directly to policies which assure adequate nutrition.

It is important to remember that our relatively poor international standing in infant mortality is due to our relatively poor low birthweight rate and postneonatal mortality rate. This poor standing is not the product of geography. It is not the product of being a heterogeneous population. Nor is it an issue of genetics. It is a product of the life conditions we tolerate and public policies we implement which affect the health of women and young children in our society.

The infant mortality problem in this country is not a product of who we are. It is a product of what we do. It is my contention that the gains of the past now force us to confront the underlying problems that remain. However, even the gains of the past are presently threatened.

An approaching period of enhanced vulnerability is also due to the restructuring of the financial base of health care in this country. The medical innovation of the past decade would have had little impact were it not for public policies which determined its functional availability to all those in need. Of particular importance has been Medicaid Program and funds for regionalization of high risk care.

Without special protection, a realignment in access based on the ability to pay could signal the deregionalization of perinatal care based on social class and result in major detrimental effects on the infant mortality rates of all but the wealthiest of our citizens.

I'm convinced that in the midst of finding lower cost methods of financing health care in this country, a process almost entirely directed at parameters of adult health care, the effective and hugely successful system of caring for high risk infants could quickly begin to unravel.

The persistence of social and racial disparity in infant mortality in the face of significant reductions in infant mortality deserves special attention. National data indicate that while infant mortality rates for all newborns have fallen, social and racial disparities persist and in some areas have actually worsened.

Our recent study in Boston found that high access to tertiary or high tech medical services greatly reduced racial and social disparities in infant and other childhood mortalities. You cannot be born in the city of Boston unless you're born into a tertiary level facility. That's the nature of health care in the city of Boston.

So the issue of differential access to high tech medical care was not important to the mortality experience of this population. What we found was that in fact equitable access to tertiary level medical care was critical for all children in need.

However, as important as this technical capacity was, it was not sufficient to elimiate racial or social disparities in infant mortality.

The technologic capacity of modern medicine could not erase the legacy of larger social inequities. Of primary concern in this regard is adequate nutrition. As a member of the Physicians Task Force on Hunger, I have visited families, hospitals, and other facilities and have seen the high toll exacted by inadequate food. This experience has augmented my research and own clinical experience, and has underscored the importance of program initiatives, particularly in the area of nutrition, to respond to adverse health outcomes.

This raises a central issue in confronting disparate infant mortality rates in this country. Medical progress can in no way guarantee equity. Policies which foster general improvements in the survival of our Nation's infants may not effect or could even worsen present disparities in infant mortality.

Equity in infant survival can only be achieved when inequity in infant survival is addressed and addressed directly. Much has been stated regarding the detrimental impact of a number of maternal behaviors, including smoking, alcohol, and drug abuse. It seems clear that reducing the prevalence of these behaviors could reduce overall levels of poor birth outcome. That seems clear.

However, there is no reason to believe that such an approach will reduce racial disparities in birth outcome. White women smoke more than black women in pregnancy and they also drink more than black women in pregnancy.

There is little evidence to suggest that the reasons for racial differences in the health of newborns lie in the harmful behaviors of their mothers. Rather, the source of disparate mortality rates lies in the societal inequities that continue to be associated with race in our society, and that heighten prenatal and postnatal risk of illness, as well as reduce access to appropriate medical care.

It is in this sense that the reduction of black infant mortality in this country means more than the mere reduction of a certain number of excess deaths. It relates directly to our more fundamental commitment to a more responsible and just society.

I clearly have great respect for the work done by the HHS scientists that were here, particularly Dr. McGinnis, Dr. Hutchins and their colleagues. However, my concern is not with good science. It is with the translation of good science into good policy.

I speak in strong support of policies which eliminate hunger and best assure adequate nutrition for women and infants. It is important to recognize that these policies are perhaps more critical today than at any other time.

A public commitment to improved infant survival will have to first deliberately protect the progress of the past two decades. More far-reaching, however, will be those health and social policies which integrate the growing power of medical understanding with our social goals of equity and maximal opportunity; a challenge that has yet to be addressed adequately by a national policy.

Thank you.

[The prepared statement of Dr. Wise appears at the conclusion of the hearing, see p. 120.]

Chairman LELAND. Thank you very much, Dr. Wise. I personally would like to thank you for coming forward and giving us that compelling testimony.

In your experience in both the research and health policy arenas, how can we place the issue of assuring a healthy pregnancy high on the agenda of policymakers and health and social services administraters?

Dr. WISE. I don't know how we can place it higher. I think that what will place it higher will be what the infant mortality rate in fact does. It's extremely sticky to social policy, and what we are predicting is that we're going to see the level of infant mortality stabilize and, in fact, enter a period of increased volatility so that the infant mortality will be its own best advocate, in that it's hard to ignore.

So, the advocacy of people like myself and Mrs. Edelman clearly must continue. But, in fact, it will be the infant mortality rate itself which will focus attention on this problem.

The tragedy of that, of course, is that stabilization of the infant mortality rate implies that there have been 5 or 6 years of stabilization when we didn't address it. How many lives were lost to wake us up. That is the tragedy.

The causes of high infant mortality are not a mystery. There are certainly scientific questions to address, and we're very anxious to begin to address them. But the issue of high infant mortality is not particularly mysterious. It is a product of what we do. It is a product of our policies.

But I'm afraid that what will press the point home, the importance of prenatal care and a good healthy pregnancy, will be the infant mortality rate itself.

Chairman LELAND. Policies are established through political conduits. And it seems that the political conduits are rather resistant to doing what is necessary to serve the interest of reducing the infant mortality rate.

I also commend the gentlemen who came from HHS. They have to adhere themselves to those policies that set parameters of their involvement and their advocacy. In particular, with the budget constraints mandated by budget reconciliation, we have to do certain things within the realm, rather, of those budget cutbacks that have, over the years now, in the last 6 years, have really been complicated, to say the least.

I guess I'm speaking more specifically to the administration that's in office right now. It's a shame that our priorities are so screwed up. We're going to spend, or we are spending $300 billion just in 1 year on a defense budget to develop weapons to destroy people, nuclear weapons and even the conventional weapons. And yet, our greatest, precious, most precious resources for the future are our children. And so many of these children will die senselessly. It can be prevented.

How do you reconcile that?

Dr. WISE. Well, first of all, I'm not sure how precious children are in our society. I think that we'd like to think of it that way. Our own children perhaps are precious to us. But as a society we've seen the divestiture of children at a State level, meaning government, and also in terms of the family to a large extent. These are issues that we will have to address.

Very often when I talk about infant mortality in a policy forum, the issue of scarce resources comes up. You know, your concerns are all fine and dandy, but what about the reality of scarce resources? My response is that a budget is now being discussed of over a trillion dollars. Ten percent of the GNP is in health care. That's not scarce resources; they are merely competitive.

The issue is how do we allow children to compete for those resources. It's not a question of scarcity, it's a question of competition, and how well the children compete in this environment is really what has changed.

Very often people point to the fact that a very small portion of the elderly are now living in poverty as compared to 20 years ago, and recognize that in fact the reverse is true for children. In no way would I like to pit the needs of the elderly against the needs of children. Clearly they have a lot more in common than in conflict.

But I raise the issue about the elderly because it is a testament to our capacity to alter the living conditions of a whole generation of people in our society. It is testimony to capacity, to our ability to influence well-being through public policy.

I raise this point to underscore the divestiture of children and highlight our potential, our opportunity to improve things for children. I have no doubt that the infant mortality rate will improve only when we address ourselves to the broader needs of children and women in our society.

There are very specific things like WIC that I think are very important. The absolute guarantee of improved regionalization rather than deregionalization is another critical factor that we cannot forget at this point because approximately 60 to 80 percent of the total decline in the infant mortality rate in the last 20 years has come from improved perinatal technology. And to lose that through inattention, that would be a great tragedy, in fact a great disgrace.

Chairman **Leland**. We just in my estimation have just made a tragic vote in the House of Representatives on an amendment sponsored by Mr. Pepper. And understandably Mr. Pepper felt it necessary to do what he did, but this amendment further restricted the trade—well, it didn't restrict it only. I guess it codified the inability for the United States to trade with Cuba.

Now, with Cuba, with its very scarce resources, has been able to compete with us, as a matter of fact, and probably better now even, with the cause of reducing their infant mortality rate, at least in the big cities they have very definitely done much better than we have.

It seems to me that given the resources that we have available to us, we would be able to do a hell of a lot better than we're doing. And I don't just have to annunciate about Cuba, but also about those other industrialized nations of course that we compete with.

I'm concerned, as you have illucidated, that we have not really shown any real caring for our children and our women who bear our children to the extent that we ought to. Maybe, just maybe what we ought to do is line up, or some means, do a documentary, if you will, showing pictures of those babies who are low birth weight hooked up to those instruments to save them in hospitals, and show that documentary on network television, prime time, and maybe we can get some public response in order that that political conduit will become more sensitive to what the needs are.

I remember in 1984 when finally, after the BBC documentary that was shown on NBC, of the suffering of the people in Ethiopia, that finally the American people rose up and said to the political conduit that we want to see something done about the suffering people of Ethiopia, and in Africa, of that matter.

As a result, we raised over $150 million in the private sector, and we allocated and appropriated $800 million from the Congress of the United States; almost purely out of response to what was seen on television and the human cry made by the American people; the same kind of thing is happening here, I mean, to some great extent, and is probably disproportionately high compared to our resources available to us to remedy or prevent those problems.

I don't know what the real answer is other than to get rid of this administration in another couple of years and do something better. But I'm really concerned that we're not doing all that we can. And it pains a person like me to chair a committee like this, to hear—you know, to have to hold a hearing like this to hear all of the testimony concerning children. I mean, children who are supposed to be the most precious beings of our society.

And I guess I speak more appropriately with greater affection and empathy now because, as Mr. Dorgan has suggested, I have a little 15-month-old child, who I'm watching grow up and am very happy to see how healthy he is. Yet, when I went to Ethiopia in February of this year, I saw kids who were orphaned by the family. They are fatter these days, and probably more nourished, if you will. But, at the same time still at great risk.

But yet, I can go to Ventar Hospital in Houston or Jeff Davis, more appropriately, in Houston, TX and see some of the most incredible circumstances afflicting young babies as we have talked about today, and can compare them with the same situation in Ethiopia and other places. It's unbelievable.

Dr. **Wise**. Yes. In discussing these issues we often are confronted with differential responses in different places to the needs of children. In my view, the great tragedy of childhood in America is that their claim to justice is tied to that of their parents, that the legitimacy of their claim to societal resources is directly tied to the legitimacy of the parent's claim.

Accordingly, the first response in a discussion or documentary showing a low-birthweight baby is, what did the mother do wrong to have such a difficult birth, or she was a drug user, or she didn't take care of herself, or she didn't get prenatal care. There tends to be enormous victim blaming as it relates to poor birth outcome.

The notion that the child's claim to successful life in infancy is somehow tied to the claim of the parents, provides much of the tension in policies like WIC, like Medicaid for young children and infants.

At some level we're going to have to make our peace with this tension so that we can develop policies that provide some level of equity of opportunity young in life, in early life, as well as in adulthood.

I have no idea what the true impact of having 1 out of 4 kids live in poverty is really going to be. Or even begin to comprehend the impact of a legacy of injustice that begins with your first breath. But sooner or later we are going to have to deal with these issues.

I am afraid that the free-fall in our international standing in infant mortality is going to continue. All the technical signs that we follow suggest that it will continue and that we have nothing in place that will, in fact, improve our standing. Rather, the other countries that are passing us by are benefiting from social programs and public policies that they have instituted over the last decade.

I am hopeful, and I think we have enormous potential, enormous capacity. But I am also quite anxious about the inability to mount an effective set of public policies directed at this issue.

Chairman **Leland**. By the way, let me qualify my statement I made about the Reagan administration. You know, I have walked a great delicate balance in advocating for the support of this committee and the Congress, as well as outside the Congress. And by no means did I mean that that was taking a dig at the Republican party because we have Republicans on this committee who are as compassionate and empathetic as I am about the situation and who want very much to do as much as they can.

However, they suffer with the guy who leads their party who is just absolutely insensitive to this issue. And I point my finger at him. Under Richard Nixon, for example, we did a lot more to improve the situation of health and caring for babies and older people than we've done in many administrations. But compared to this one, I just get caught up in this.

I just came back from the Soviet Union where they are advocating now for openness and all of that and we were talking about the reduction of arms. And I was so proud of the Speaker of the House of Representatives, who used some figures that I had given him about how 40,000 people who die every day of starvation in this world. That's 28 people a minute, and 21 of those people are children. 21 children per minute out of 28 die of malnutrition and starvation in this world.

He used those figures and he said that wouldn't it be great if we could take some of those billions of dollars and billions of rubles that you and I and we are spending prospectively and work together and cooperate and help to solve the problem of hunger in the world. I mean, what better statement could have been made in a better place than in the center of the universe where the debate continues about this escalating problem of—the potential war and destruction of all of us.

I mean, I just don't understand. I don't understand and it seems so simple to me that we are to prioritize our moneys, our resources, our energies. I mean, it wouldn't take anything if we could take $1 billion of money that we used to build a Trident submarine—and not build that Trident submarine next year.

You answer this as an expert. What could we do with a billion dollars to reduce the infant mortality rate next year?

Dr. **Wise**. There are three arenas of importance—I can think of a lot of uses for a billion dollars, but for our purposes today, three general areas. The first is to protect the regionalization system in caring for all women and children in high need, that is No. 1.

The second is to move away from our acceptance of 40 percent of black women not getting prenatal care after the first trimester. We need to improve prenatal care, that's No. 2.

And the third is to improve the coverage and quality of programs related to the basic social condition of children. That includes nutrition programs, housing programs, income support, education programs.

So I see the three arenas of critical importance being the protection of regionalization, the second being prenatal care needs to be improved greatly; and the third, that social conditions and nutrition levels for women and young children need to be improved greatly as well.

Chairman **Leland**. Incredible. Dr. Wise, thank you very much for your testimony.

Dr. **Wise**. Thank you.

Chairman **Leland**. I'm sorry you had to wait so long, but the business of Congress goes on.

Dr. **Wise**. It was well worth it.

Chairman **Leland**. And I just want to thank for the record all of the participants today in the three different panels, the discussion. I thank the people who are here, both staff and otherwise, for their participation by just—this great day of hearings.

Thank you all very much.

[Whereupon, the hearing was adjourned at 12:45 p.m.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

This morning's hearing deals with the most shocking evidence of our failure to solve the problem of hunger and malnutrition in the United States. Our failure is clear from the statistics on infant mortality in the United States. Over the past three decades, the U.S. infant mortality rate has declined from sixth among the top 20 industrial nations to a tie for last place.

Our poor record has worsened in recent years. The Children's Defense Fund has documented our lack of progress in an excellent report released earlier this year. Indeed we are honored this morning to have as our first witness, the learned and eloquent President of the Children's Defense Fund, Marian Wright Edelman. Some of the startling statistics on our record in this area which the Children's Defense Fund report documents are the following:

- Between 1983 and 1984, infant mortality rates increased in six of America twenty-two largest cities.
- After a nationwide increase in the mortality rate among infants twenty-eight days of age to one year of age in 1983 -- the technical term for infant mortality among this age group is the postneonatal mortality rate -- this measure in 1984 declined only back to the unacceptably high 1982 level.

- In 1984, for the fifth consecutive year, there was no progress in reducing the percentage of infants born to women who received late or no prenatal care.
- At the current rate of progress, the nation and the states will fail to meet nearly all of the Surgeon General's 1990 Objectives for reducing infant mortality, the number of low-birthweight births, and the number of women who receive late or no prenatal care.

While the causes of infant mortality are complex and the provision of adequate nutrition alone will not solve the problem, programs are now in place which could end hunger and malnutrition, thus significantly reducing infant mortality. It disresses me that we are not willing to make the resources available to adequately fund these programs. For example, the Special Supplemental Food Program for Women, Infants and Children (WIC) has a proven track record of reducing infant mortality and low birth rate. WIC also has a proven track record of reducing government health care costs.

Tragically, due to funding constraints, WIC comes nowhere near meeting the need. More than 5 million women and infants eligible for WIC benefits do not receive them because this program only serves 39 percent of those eligible. The cost to fully fund WIC would be nearly $3 billion over the current funding level.

The long run cost of our failure to solve the Federal deficit problem so that we can get on with the business of ensuring that every American child gets a chance to survive is evident in the significant effort required for us to get a $100 million increase for WIC in the First Budget Resolution for Fiscal Year 1988. With a $3 billion need, $100 million is only a down payment on meeting our responsibilities to our nation's children.

We are truly privileged this morning to have a number of experts on the problem of infant mortality. They can tell us how to reduce infant mortality. We in turn, as elected officials, must translate this knowledge into effective, adequately funded programs so that we can reverse our shameful record of unacceptably high infant mortality.

PREPARED STATEMENT OF MARIAN WRIGHT EDELMAN, PRESIDENT, CHILDREN'S DEFENSE FUND

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to testify before you today. I would like to submit a written statement for the record, as well as a copy of The Health of America's Children, CDF's most recent analysis of child health trends for the nation, the states and America's largest cities. I want to commend you, Mr. Chairman, for holding these hearings today to focus national attention on one of the major social problems facing America, namely, the poor health status of some its most vulnerable citizens -- low income and minority infants and young children. I also want to thank you in behalf of all of us at the Children's Defense Fund for your enduring commitment to bettering the lives of all children and their families.

The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor, minority and handicapped children. Our goal is to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of school, suffer family breakdown or get into trouble.

For more than 15 years, CDF has placed a major focus on reporting the unmet health needs of infants and chidlren and working to ensure that all children have access to early and comprehensive medical care. My testimony this morning will review why there has never been a more urgent need for action than there exists today. With your help, Mr. Chairman, and that of your distinguished Committee members, we want to set this nation on a solid course for finally ensuring that all children have that which we know makes a real difference -- the best possible start in life and good health care throughout childhood.

I would like to begin with the story of a child who did not receive the best possible start in life -- one from your home state, Mr. Chairman:

> On September 12, 1986, Gloria A went into labor in Cameron County, Texas. The A family, like hundreds of other families in Cameron County, had no savings and no health insurance. They planned to have a home delivery with a partera (a lay midwife). But it soon became evident that Mrs. A's labor was not normal. She went to the community health center, where she had received prenatal care. The attending obstetrician discovered that her baby was in a "breech" position and determined that an immediate Caesarean section delivery would have to be performed. After placing Mrs. A on intravenous equipment and getting her into a medical van, the physician called the hospital to say he was admitting a patient for an emergency delivery.
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> When Mrs. A and her husband arrived at the hospital, however, she was not admitted as her physican had instructed. The hospital refused to accept her because the family was poor and uninsured. Texas provides a special program for indigent women like Mrs. A that would have helped pay for the delivery, but the hospital refused to

participate in this program. The other hospital in Brownsville also refused to admit uninsured patients, and the next closest hospital with obstetrical facilities that might admit someone of Mrs. A's limited means was thirty-five to forty miles away.

While in active labor, Mrs. A was met by a member of the hospital business office staff, who informed her that because she and her husband were uninsured they would have to pay $3,000 to be admitted. (The delivery actually would cost about $1,500.) The staff person told the A family that if they insisted upon being treated without paying, the hospital would bring a collection action to repossess everything they owned.

Shaken by her condition and frightened by these threats, Mrs. A and her husband left the hospital. They were not permitted to leave, however, until she signed a form stating that she was leaving against the medical advice of the hospital.

Mrs. A finally delivered her baby a day later at a hospital that admitted her without charging her. As a result of the delay, the baby's umbilical cord had collapsed and oxygen flow to the brain was restricted. Physicians do not know at this point whether or not the infant will suffer lifetime disabilities as a result.

Every child needs decent health care at every stage of his of her development. Good medical care must begin with comprehensive care provided early in and throughout his or her mother's pregnancy, labor, and delivery. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No pregnant woman should be denied maternity care because she does not have the money to pay for it. No child -- whether his or her need is for immunizations, treatment for a strep throat, dental care, hospitalization, medicines, eyeglasses, speech therapy necessary because of a hearing loss, or long-term care at home -- should go without health care because his or her family cannot afford it.

Preventive care during all stages of a child's life pays off in improved health as well as in financial savings to society. The alternative is higher human, social, and economic costs.

Early and continuous maternity care (which includes regular medical exams, any needed treatment, nutrition counseling, a safe and appropriate delivery, and support services) can reduce mortality and low birthweight among infants by more than 25 percent. Low-birthweight babies are twenty times more likely than others to die in the first year of life and are at significantly greater risk of developing such permanent handicapping conditions as retardation, cerebral palsy, and autism. Children born to mothers who recive no prenatal care are three times more likely to die in their first year of life than are other babies.

Because it prevents more serious or long-term problems, early and continuous health care for pregnant women saves our society money. Comprehensive prenatal care is highly effective in reducing the incidence of prematurity and low birthweight. For every hour that high-quality prenatal services postpone the birth of a premature infant, our society can save $100. Every dollar spent to provide prenatal care saves more than $3 in the first year of an infant's life alone by reducing the need for expensive hosptial stays among babies. That same dollar saves an average of up to $11 in total medical expenses over the lifetime of a child, because the child is less likely to be born with permanent disabilities.

Early and continuous health care for children after birth saves lives and helps prevent unnecessary pain and suffering. It also averts or minimizes long-term health problems, helping children grow into healthy, productive adults.

High-quality preventive, primary, and remedial pediatric health care can ensure that problems that can develop during infancy, such as respiratory, neurologic, or orthopedic impairments, are detected and treated. Health professionals working with low-income school children have found that as many as 80 percent are suffering from one or more untreated medical conditions. Such untreated problems as vision, hearing, and dental problems, anemia, and mental health and developmental conditions can impair substantially a child's ability to attend or benefit from school and prepare for later life. Many of these conditions can be treated and remedied, averting long-term harm to the child.

Despite the major human and financial benefits we gain by investing in child health, it is all too clear by any health measurement, that we have failed to make this investment and that we are now reaping the whirlwind of our failure in the form of an overwhelming excess of childhood death and disability. While health measurements for America's poorest children are troubling at any age, I would today like to focus on the special problem of infant death and disability. I wish to make three central points:

- First, that this nation has made utterly inadequate and unacceptable progress in reducing infant mortality and that this lack of progress has cost us thousands of lives, and billions of dollars and has dramatically affected our international standing among the world's leading industrialized nations.
- Second, that other key measurements of child health status and access to health care indicate that young children with special health needs are confronting enormous barriers to obtaining adequate health care.

- Third, in the face of stagnating child health indicators, our most important public health and nutritional programs have been permitted to stagnate and erode and in many instances, have been reduced outright.

I will conclude my remarks with recommendations for change.

I. United States progress in reducing overall infant mortality is at a virtual standstill.

National Findings:

Following two decades of rapid decline, the nation's progress in reducing infant mortality has been slowing since 1981. In 1984 (the most recent year for which national data are available), nearly 40,000 of the more than 3.6 million children who were born in the United States died before their first birthday, a rate of 10.8 infant deaths per 1,000 live births. While this figure represents a modest 4 percent decline from the 1983 rate, experts anticipate no similar improvements for 1985.

Futhermore, we have failed to make progress in closing the black/white infant mortality "gap." Despite some reductions in the black infant mortality rate, black infants continue to die at nearly twice the rate of white infants. By 1984, the black/white infant mortality gap had widened to a point experienced in only two other years since 1940 (1964 and 1983). Had the black infant mortality rate equalled the white rate, 5,309 fewer black infants would have died that year.

Similarly, our postneonatal mortality rates (deaths to infants after the first 28 days) remain unacceptably high. After a nationwide increase in 1983, 1984 postneonatal mortality rates returned only to their 1982 levels. Thus, no real progress was made.

A high postneonatal mortality rate, which is often thought of as an indicator of the environment in which infants live, is particularly disturbing in a country as wealthy as the United States. The rate of death among our older infants is a grim reminder of the conditions of poverty in which nearly one-quarter of American children under age six live.

International Findings:

As a result of the stagnation in infant health improvements, the United States' international ranking on infant mortality has deteriorated substantially over the past thirty-five years. Using United Nation's Children's Fund (UNICEF) data, we compared the U.S. rate of decline in infant mortality to those of 19 other industrialized nations with comparable standards of living and reliable vital statistics. We found that the United States' infant mortality ranking had fallen from sixth place in the 1950-1955 period to a tie for last place in the 1980-1985 time period. Eighteen of the other 19 nations, experienced greater rates of improvement during the 35 year period (with the sole exception of Australia).

In Japan, for example, the infant mortality rate for the 1950-55 period was 51, as compared to a United States rate of 28 (ranking seventeenth and sixth respectively). By the 1960-65 period the Japanese rate had been reduced by more than 50 percent, while the United States rate had declined by only 11 percent. Japan's rate continued this dramatic decline through the 1980-1985 period, for a total decline of 88 percent. The Japanese average infant mortality rate for 1980-1985 was 6 deaths per 1,000 live births, placing it first among twenty industrialized nations. In contrast, the United States rate's total decline was 61 percent for the 35 year period, leaving it tied for last place with a rate of 11 deaths per 1,000 live births.

We believe that numerous factors account for our nation's failure to reduce infant mortality as rapidly another industrialized countries. First, each year the United States experiences a relatively high proportion of low birthweight births, which is exacerbated (but by no means caused soley) by our high rate of teenage childbearing. A second key factor which distinguishes the United States from countries that have reduced infant mortality rates more rapidly is the provision of maternity services. With the exception of South Africa, the United States stands alone among industrialized nations in its failure to assure pregnant women access to prenatal and delivery services through either a public health service or universal health insurance. Our public maternity policies lag far behind those of 75 other nations who ensure the provision of basic health and social supports during pregnancy and early childhood, such as medical and nutritional care and some form of income support or protection (such as a family allowance or a parental leave policy).

State and City Findings:

The nation's overall failure to make progress in reducing infant mortality is fearfully magnified in individual states and cities.

Among states, clear regional patterns in infant mortality rates can be discerned.

- In 1984, the states with the highest rates of infant mortality tended to be concentrated in the South. With the exception of Illinois, the ten states with the highest 1984 overall infant mortality rates were all southern. Southern states also exhibit the highest rates of neonatal mortality. But while southern states had high overall infant mortality rates in 1984, five of the ten states with the highest 1984 black infant mortality rates were located outside the South. The ten states were Connecticut, Delaware, Mississippi, Virginia, South Carolina, Washington State, Pennsylvania, Illinois, Michigan, and the District of Columbia.

- Furthermore, in 1984 there continued to be enormous variations from state to state in infant mortality rates, the percentage of low-birthweight babies, and the proportion of infants born to women who had received early or late or no prenatal care. For example, in 1984 a white infant born in Wyoming was nearly one and a half times more likely to die in the first year of life than a white infant born in North Dakota. A black infant born in the District of Columbia was 1.7 times more likely to die in the first year of life and more than two times more likely to die in the first twenty-eight days of life than a black infant born in Massachusetts. A black infant born in Illinois was nearly 1.6 times more likely than one born in Maryland to die during the postneonatal period.

City progress in reducing infant mortality is lagging.

- Between 1983 and 1984, infant mortality rates rose in six of America's twenty-two largest cities. Milwaukee, Wisconsin experienced a particularly notable 1984 infant mortality rate. Milwaukee's 1984 overall infant mortality rate of 14.2 deaths per 1,000 live births stood at the highest point in five years and was higher than the city's average infant mortality rate for the preceeding four-year period.

- In general, infant mortality in America's largest cities tends to be more serious than for the nation as a whole. Only five of America's twenty-two largest cities had 1984 infant mortality rates equal to or lower than the national average. These were Columbus, Phoenix, San Diego, San Francisco, and San Jose.
- The disparity between black and white infant mortality rates in America's twenty-two largest cities in 1984 was startling. In seven cities, (Philadelphia, San Diego, Chicago, Cleveland, Indianapolis, Los Angeles, and Memphis) black infant mortality rates were more than twice as high as white rates. (The national black infant mortality rate is 1.96 times higher than the white rate.) The highest white infant mortality city rate among the cities in 1984 (13.8 deaths per 1,000 live births in Detroit) was nearly identical to the lowest black city rate that year (13.5 deaths per 1,000 live births in Columbus).
- A black infant born in Indianapolis or the District of Columbia in 1984 was more likely to die in the first year of life than an infant born in Costa Rica, a country much poorer than ours.
- The infant mortality rates of certain cities stand out. For example, regardless of whether the District of

Columbia is considered a state or city, its 1984 black infant mortality rate was shockingly high. In 1984, the District's black infant mortality rate ranked twenty-first worst out of twenty-two large American cities, and last among thirty-two states with a sufficient sample size of black live births.

- Urban infant mortality rates can vary dramatically on an intrastate as well as interstate basis. For example, in 1984 there was a remarkable difference in infant mortality rates between Columbus, Ohio, and Cleveland, Ohio. A black infant born in Cleveland was 1.7 times more likely to die in the first year of life than one born in Columbus.

An unacceptably slow rate of progress reducing infant death means that we will not meet most of the modest maternal and infant health objectives for the Nation established by the Surgeon General of the United States.

In 1978, the Surgeon General of the United States established a set of 1990 Health Objectives for the Nation in the area of infant health. These objectives were reaffirmed in 1984 by the Reagan Administration. CDF has calculated the nation's and states' rates of progress in meeting these objectives. In determining these rates we have included the years of greater progress (generally, 1978 to 1981) as well as those of slower progress (1982 to 1984). As a result, even the bleak picture described below may be overly optimistic. If the slower rates of progress that generally prevailed in 1982, 1983, and 1984 continue throughout all, or most of, the rest of the decade (and provisional 1985 infant mortality rates suggest that this may well be the case), even fewer states and fewer subgroups than are described below will meet these Surgeon General's objectives. The Public Health Service of the U.S. Department of Health and Human Services reported to Congress in 1985 that the 1990 annual infant mortality goal would not be met based on 1982-1984 trends. In a more recent study, *The 1990 Health Objectives for the Nation: A Midcouse Review,* the U.S. Department of Health and Human Services concurred that at its current rate of progress, the United States will not meet the 1990 infant mortality goal.

Overall, it is clear that inadequate progress toward the Surgeon General's Objectives is being made. For some key measurements, a number of states actually are moving in the wrong direction.

Objective 1: Infant Mortality

Surgeon General's Objective: By 1990, the national infant mortality rate (deaths of children younger than one year old) should be reduced to no more than nine deaths per 1,000 live births, with no county and no racial or ethnic subgroup having an infant mortality rate in excess of twelve deaths per 1,000 live births.

Findings:

Based on CDF's five-year trend calculations, we have concluded that the nation will meet the Surgeon General's overall 1990 infant mortality goal. However, CDF's calculations are more conservative than those performed by the Department of Health and Human Services and therefore have yielded a larger average annual rate of progress. The Department's recently published Midcourse Review of the Surgeon General's 1990 Health Objectives, discussed above, found that "based on progress to date, achievement of this objective (infant mortality) is questionable. Applying the 1983-85 rate of decline (9 percent) to the final 1983 figure yields a projected rate in 1990 of 9.2 per 1,000," which is above the 9.0 goal.

Both CDF and the Department have concluded that the goal will not be met for key racial and ethnic subgroups.

- First, The Surgeon General's Objective for infant mortality among racial and ethnic subgroups will not be met nationally for blacks.
- CDF's state trend analysis shows that twenty-two of the thirty-four jurisdictions with measurable numbers of black infant deaths in 1984 will not meet the infant mortality Objective for black infants. These are Alabama, Arizona, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Mississippi, New Jersey, North Carolina, Ohio,

Pennsylvania, South Carolina, Tennessee, and Virginia. Two additional states, Washington and Wisconsin, actually are moving in the wrong direction.

- Third, seventeen of the thirty-one jurisdictions (thirty states and the District of Columbia) with measurable numbers of nonwhite infant deaths in 1984 will not meet the goal for nonwhite infants. These include: Alabama, Alaska, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Michigan, Mississippi, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. A nineteenth state, Wisconsin, actually is moving in the wrong direction.
- Thirteen jurisdictions (Alabama, Colorado, Connecticut, District of Columbia, Georgia, Indiana, Kentucky, Michigan, Mississippi, New Hampshire, South Carolina, Virginia, and Wyoming) will not meet the overall infant mortality goal. Finally, many cities and substate regions will not meet the goal.

Objective 2: Neonatal Mortality

Surgeon General's Objective: By 1990, the neonatal mortality rate (deaths of infants younger than twenty-eight days of age) should be reduced to no more than six deaths per 1,000 live births.

Findings:

Both CDF's and the Department's analyses show the nation will meet this 1990 Objective.

- While states' progress generally has been adequate to assure that this objective is attained, five jurisdictions, (the District of Columbia, Georgia, Michigan, South Carolina, and Virginia), show inadequate annual rates of progress to meet the goal.

Objective 3: Postneonatal Mortality

Surgeon General's Objective: By 1990, the postneonatal mortality rate (deaths of infants age twenty-eight days to one year) should be reduced to no more than 2.5 deaths per 1,000 live births.

Findings:

Both CDF and the Department project that the nation as a whole will not meet the Surgeon General's 1990 goal.

- In addition, forty-four jurisdictions with sufficent postneonatal deaths to compute progress will not meet the goal. These are Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington State, West Virginia, Wisconsin, and Wyoming.

- Some of these states actually are moving in the wrong direction. These are Alaska, Colorado, Connecticut, Idaho, Kentucky, Maryland, Missouri, Montana, Nevada, Pennsylvania, South Dakota, Utah, Washington State, and Wisconsin.

Objective 4: Low Birthweight Babies

Surgeon General's Objective: By 1990, low birthweight babies (those weighing 5.5 pounds or less at birth) should constitute no more than 5 percent of all live births, and in no county or racial or ethnic subgroup of the population should more than 9 percent of all live births be low birthweight.

Findings:

Both CDF and the Department project that the nation will not meet the Surgeon General's overall objective for low birthweight and will not meet the goal for black infants.

- CDF's analysis of state trends revealed that only ten states have met or will meet the objective for all races. These are Alaska, Idaho, Iowa, Minnesota, Nebraska, New Hampshire, North Dakota, South Dakota, Washington State, and Wisconsin. Six states (Arizona, Delaware, Hawaii, Maine, Oregon, and West Virginia), are moving in the wrong direction.

- Only seventeen states will meet the low birthweight goal for white infants.
- Only fifteen of the forty-two jurisdictions with sufficient numbers of black infant deaths to compute trends will reach the low birthweight goal. Ten states actually are moving in the wrong direction. These are Arizona, Illinois, Kansas, Louisiana, Michigan, North Carolina, Oregon, Pennsylvania, Virginia, and West Virginia.
- Only twenty of the forty-eight jurisdictions with statistically significant numbers of nonwhite low birthweight births will meet the objective for nonwhite infants. These include: Alaska, Arizona, California, Hawaii, Idaho, Iowa, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Utah, Washington State, and Wyoming. The other twenty-eight jurisdictions will not meet the goal.

Objective 5: Early Prenatal Care

Surgeon General's Objective: By 1990, 90 percent of all pregnant women should obtain prenatal care within the first three months of pregnancy.

Findings:

Based on CDF's and the Department's analyses of recent trends, the nation will not meet the Surgeon General's goal.

- No state will reach the goal at its current rate of progress. Ten jurisdictions are moving in the wrong direction. These are Connecticut, District of Columbia, Maryland, Massachusetts, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington State.

- In some states, the lack of access to early and appropriate prenatal care is absolutely astonishing. An infant born to a black woman in New York and the District of Columbia in 1984 was more than three times more likely than one born to a black woman in Mississippi, and more than four times more likely than one born to a black woman in Massachusetts, to have a mother who received late or no prenatal care.

The cost of our slow progress has been high. By the end of this decade, at its current rate of progress, the nation will have spent at least $2.1 billion in first-year costs alone to care for the excess numbers of low birthweight infants who need extensive medical care and whose tragic situations could have been averted had the nation moved more rapidly to reduce the incidence of low birthweight.

On average, the nation's annual rate of progress between 1978 and 1984 in reducing low birthweight has been only 40 percent of what it needs to be if the 1990 goal is to be achieved. At the nation's average annual rate of progress, we will not meet the Surgeon General's 1990 low birthweight goal until the year 2044. Given our consistently slow rate of progress and the absence of any foreseeable, significant improvement in the rate of progress during the rest of the decade, it is evident that the nation will continue to experience an excessive number of low birthweight births. We estimate that in light of the nation's slow rate of progress in reducing low birthweight, between 1978 and 1990 the nation will experience an excess of 300,701 low birthweight births (including 57,133 very low-birthweight births) that could have been avoided had progress been sufficient to achieve the goal.

II. Other measurements of child health and access to early and comprehensive care indicate considerable problems.

Infant mortality and morbidity are perhaps the clearest bellweather of a nation's health status. But other measurements shed light on the problem, as well.

A. Low birthweight birth

The incidence of low birthweight for the nation in 1984 remained virtually unchanged from earlier years. Between 1983 and 1984 the percentage of low birthweight babies (born weighing less than 5.5 pounds) declined only one tenth of one percent from 6.8 percent to 6.7 percent. While the causes of low birthweight are not entirely understood. Several studies have demonstrated the link between low birthweight and access to medical and nutritional services during pregnancy.

The serious consequences of low birthweight have been widely documented. Infants born at low weight are 20 times more likely to die in the first year of life and face significantly higher risk of disability than normal weight infants. Low birthweight infants often suffer from autism, retardation, cerebral palsy, learning disabilities, and vision and hearing disorders.

B. Prenatal care

In 1984, for the fifth consecutive year, there was no progress in reducing the percentage of infants born to women who received late or no prenatal care. Moreover, the percentage of infants born in 1984 to women receiving prenatal care in the first three months of pregnancy increased by only three tenths of one percent. By comparison, between 1969 and 1979 the percentage of infants born to women receiving late or no care was reduced by 37 percent and the average annual percentage increase for women receiving early care was 1.4 percent.

Inadequate prenatal care can have serious implications for infant health. For example, between 1978 and 1985 the number of infants infected from birth by their mother's syphilis rose by 150 percent. According to the Centers for Disease Control (CDC), this increase in the rate of congenital syphilis resulted in part from the lack of adequate prenatal care experienced by women. Experts also report that early and comprehensive prental care can reduce maternal mortality, help prevent low birthweight, and help reduce infant deaths.

C. Immunizations

Childhood immunization rates represent a key indicator of how adequately protected against major health crises children are and how accessible primary pediatric health care is.

- In America today approximately 35-40 percent of preschool age children (1-4 years) are inadequately immunized against measles, rubella, diptheria, tetanus, or petussis. The Centers for Disease Control report that the measles rate increased by 34 percent between 1984 and 1985. The CDC estimates that preschool age children accounted for one in three of the measles cases in 1985 and that 74 percent of the cases among preschool chidlren were preventable.
- Staggering inflation in vaccine costs have led to a decline in the purchasing power of our childhood immunization program funds. Vaccine costs have increased by as much as 500 percent in recent years. As a result, the number of children immunized through public programs decreased by as much as 20 percent per year.

III. Despite the great need, major public and private

programs are gravely inadequate to meet the needs of poor children.

A. Medicaid, the major public insurance program for families with children, is covering fewer children

Medicaid, established in 1965, is the nation's largest public health financing program for families with children. Unlike Medicare, which provides almost universal coverage of the elderly without regard to income, Medicaid is not a program of universal or broad coverage. Rather, it is based on need. Eligibility depends on having extremely low income.

Because Medicaid is fundamentally an extension of America's patchwork of welfare programs, it makes coverage available primarily to families that receive welfare. In addition to these restrictive eligibility categories, Medicaid excludes millions of poor families because of its financial eligibility standards, which for most families are tied to those of AFDC. In more than half the states, a woman with two children who earns the minimum wage (about two-thirds of the federal poverty level for a family of three in 1986) would find that she and her children are ineligible for coverage. By 1986, the combined impact of Medicaid's restrictive categorical and financial eligibility standards reduced the proportion of the poor and near-poor covered by the program to only 46 percent -- down from 65 percent a decade earlier.

As a result of improvements enacted by Congress in 1984 and 1986, there is some hope that the number of uninsured low-income pregnant women and children will be reduced somewhat in the next few years.

- The Deficit Reduction Act of 1984 mandated that states provide Medicaid coverage to all children younger than five with family incomes and resources below AFDC eligibility levels.
- The Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1986 together mandate coverage of all pregnant women with income and resources below state AFDC eligibility levels.
- The Sixth Omnibus Budget Reconciliation Act, passed in late 1986, permits states at their option to extend automatic Medicaid coverage to pregnant women and children younger than five with family incomes less than the federal poverty level but in excess of the state AFDC eligibility levels.

If fully implemented in every state, these amendments will reduce by 36 to 40 percent the number of uninsured pregnant women and young children nationwide.

However, even if fully implemented, these new laws will not fill all of Medicaid's gaps. Medicaid still does not reach many low-income children after they turn five years old. Currently, twenty states continue to deny Medicaid to very poor children older than five who do not receive AFDC because they live with both parents. Neither do these new laws aid millions of uninsured, nonpregnant, poor parents, whether they are working or unemployed. The recent improvements are unlikely even to offset the years of stagnation and erosion that Medicaid has experienced.

Filling the gaps is a slow process. In FY 1985, Medicaid served 10.9 million children younger than twenty-one -- more than 400,000 fewer than had been served in FY 1978. The lag occurred despite the fact that FY 1985 was the first year Deficit Reduction Act amendments were in effect and about a dozen states had enacted additional optional Medicaid child coverage improvements. And it occurred even though the number of children in poverty rose from 10 million to more than 13 million in the same period.

B. Gaps in the public and private insurance systems leave millions of children uninsured

Of all age groups, children are most affected by weaknesses in the public and private insurance systems. In 1984 children made up 25 percent of all Americans younger than sixty-five, but one-third of America's 35 million uninsured persons.

The uninsured are disproportionately poor, and include many working families as well. Medicaid's many gaps include a virtual exclusion of poor working families -- a situation exacerbated by changes enacted by Congress and the Reagan Administration in 1981. As a result, a child in a poor working family is 1.8 times more likely to be completely uninsured than one in a poor non-working family. The majority of uninsured children live in families with a working parent or parents.

While Medicaid has made a huge difference for poor families' access to health care in the past two decades, the proportion of poor children without any health insurance (public or private) still is more than three times that of children whose families' incomes over 200 percent of the poverty level. One-third of all poor children are completely uninsured and another third are insured for only a portion of each year. More than two-thirds of all uninsured children live in families with incomes less than 200 percent of the federal poverty level.

In addition to poverty, certain other characteristics describe groups of children who are disproportionately likely to be uninsured:

- Children in single-parent households. By 1984 one in five children lived in single-parent families, a figure that has been rising steadily since the 1950s. Such families are significantly more likely than two-parent families to be poor. Women and children living in families headed by single parents run two and one-half to three times the risk of being uninsured as children living in two-parent families.
- Black children. Because black children are more likely

to be poor, they are also more likely to be uninsured. One in four black children, compared to one in six white children, is uninsured.

Thus, the American children most likely to be uninsured are among the nation's poorest and most vulnerable. Their families cannot compensate for the lack of health insurance coverage from an employer or the government. Not surprisingly, uninsured poor children are 40 percent less likely to receive needed health care, particularly preventive services, than are their insured counterparts.

C. Excellent outpatient public health programs exist but their funding is too small to serve the millions of uninsured Americans

Low-income pregnant women and children who are eligible for neither private insurance nor Medicaid are completely dependent on a fragile and porous web of federal, state, and local public health programs, plus a rapidly eroding system of private "charity" care. Many of these programs are aimed at particular populations and are not intended to pick up the pieces from a deteriorating insurance system. Most have been harmed seriously since 1981 by funding cuts or freezes that fail to take inflation into account. None is funded at a level that is adequate to serve the poor and uninsured who need care. All fall short of being able to meet the increased need that has occurred in the 1980s. But when looked at in terms of their core purposes and their results, the programs have been extremely successful.

The Title V Maternal and Child Health Block Grant

This federal grant program primarily funds clinics that provide free or reduced-cost basic maternity and pediatric care to millions of poor and near-poor women and children each year. The program also provides medical care to thousands of ill or handicapped children with special health care needs. In 1983, 235,000 pregnant women and millions of children were served by clinics and providers funded wholly or in part by Title V. Title V clinics have proven instrumental in reducing the incidence of death and disability among the women and children served.

Community and Migrant Health Centers

Nearly 800 federally funded Community and Migrant Health Centers served more than 5 million persons in 1985. Among those served, about two-thirds were children or women of childbearing age. Eighty percent had family incomes lower than 150 percent of the federal poverty level.

Immunizations

Federal immunization grants are used to purchase and administer life-saving vaccines to millions of American children. The history of this program -- including its successes as well as its current funding shortfalls -- illustrates the ups and downs common to vital federal public health programs.

Through the immunization program, we have virtually eradicated such fatal and crippling diseases as diphtheria, pertussis, congenital rubella, smallpox, and polio. Our nation has achieved a 99 percent reduction of these infectious diseases that previously led to suffering, permanent damage, and death.

The advent of the measles vaccine has caused a revolution in child health. Virtually every American child born before the mid-1960s contracted measles. In addition to the discomfort of the infection, which lasted one to two weeks, there was an added risk of such complications as ear infections, pneumonia, brain damage resulting from encephalitis, and death.

Instead of millions of cases each year, fewer than 2,000 to 3,000 cases have occurred annually in recent years, (although an upswing has occurred since 1983 in the measles rate). The vaccine has meant that 80,000 children who would have died in the past twenty years are healthy and thriving today because they did not acquire measles. Institutions serving children with severe mental retardation have had 80,000 fewer patients over the past two decades because of resulting reductions in the number of children suffering brain damage.

However, the nation's ability to maintain and expand its program of life-saving immunization now is threatened seriously. Over the years, about 50 percent of our childhood immunization program has been supported by the federal government. However, since 1980, costs have risen dramatically:

- o DPT (diphtheria, pertussis, tetanus) vaccine costs to the government rose from 11 cents per dose in 1980 to $3.53 per dose by 1986 -- a price thirty-two times greater.
- o Measles, mumps, or rubella vaccine costs to the program rose from $2.71 per dose to $8.47 per dose -- more than a 200 percent increase.

Since, at best, the federal government buys only 50 percent of needed childhood vaccines, physicians and clinics have to supplement their supplies heavily through purchases. Inflation has been equally disastrous here.

Yet the federal immunization program has not even come close to keeping pace with these increases. Since 1982, the vaccine program grew by only 166 percent -- from $28.2 million to $75 million in FY 1987. The cost of fully immunizing a child went from $6 in 1980 to more than $30 in 1986 -- a 400 percent increase in costs in the face of the much smaller increase in the vaccine program. Prices are expected to rise another 50 percent in 1987.

In FY 1987, the $75 million federal immunization grant program will fully vaccinate 2.5 million children if the $30 per child cost holds. In 1980, that same amount of money would have vaccinated 12.5 million children. And we are beginning to see the effects of the failure of the federal program to keep pace. The number of children immunized by public programs has dropped by at least 20 percent for each of the past four years. From 1985 to 1986, the number of children catching measles rose from fewer than 3,000 to more than 6,000, a rate of increase more than twice the rate of increase of AIDS cases.

The Supplemental Food Program for Women, Infants and Children (WIC)

Despite the link between birthweight and nutrition, in no state are all women and children who are eligible for WIC actually served. Nationally, WIC reached only 40 percent of eligible women and children in 1986. In eleven states (Nebraska, Arkansas, South Dakota, Washington State, California, Utah, Arizona, Idaho, Alaska, New Mexico, and Hawaii) fewer than one-third of all eligible women and children were served

The inadequacy of these programs leaves large areas of the nation and millions of women and children unserved. A 1986 CDF survey of maternity and pediatric services offered by state maternal and child health agencies revealed the following:

- While forty-eight states reported offering publicly subsidized maternity care programs, in only thirteen were services available statewide. In only one was there enough funding to serve even that state's very modest target population (uninsured women with family incomes at or below eligibility levels for WIC.

- Only twenty-three states paid for hospital deliveries for even selected categories of uninsured women, although twenty-eight states admitted that hospitals within their borders have turned away uninsured pregnant women in labor. Another twenty-three reported that hospitals refuse to arrange in advance for delivery services for uninsured women who cannot pay a preadmission deposit (either all or part of the bill).
- Only forty-six states reported that public pediatric clinics were available, and of these only thirteen maintained such clinics on a statewide basis. In no state were comprehensive health services (for both well child and sick child care) available statewide. Only two states covered any hospital care for uninsured sick children other than for a small number of children with selected medical conditions, who are known as children with special health care needs. Conditions commonly excluded from state programs for children with special health care needs (formerly known as state crippled children's programs) include such serious ones as sickle cell anemia, cancer, diabetes, and asthma.

CDF Recommendations

In order to assist the growing number of families in need and ensure a minimum of health care coverage, CDF recommends that by 1992 at the latest:

- No woman or child who is eligible for supplemental nutrition assistance under the WIC program should go without these benefits. For this reason, CDF's Legislative Agenda calls for sufficient funding to increase participation rates substantially for each of the next five years, so that by 1992 all eligible needy women and children are served.

- All families should have access to affordable, adequate health insurance. CDF recommends a gradual phase-in of such a program. Specifically we ask this Committee's support in ensuring that the Fiscal 1988 Budget contains sufficient funds to enact H.R. 1018 and S.422, the "Medicaid Infant Mortality Amendments of 1987", which would expand pregnant women's, infant's and children's eligibility for Medicaid. A next step would be to permit states to extend Medicaid to all members of families and all individuals living below the federal poverty level, rather than only young children and pregnant women. In additon, we propose that states be given the option to institute a program under which uninsured moderate-income families with incomes above the federal poverty level would be able to purchase Medicaid for an income adjusted premium. CDF recommends that within the next ten years this program be instituted nationwide for all individuals and families without group health coverage. Funding would come from a number of sources, including individual premiums, general revenues, and dedicated taxes, such as a small employer payroll tax and a surtax on all group health insurance plans.

- All families should have access to affordable, appropriate health providers. CDF recommends that funding for the Title V Maternal and Child Health Block Grant and the Community and Migrant Health Centers program should be sufficient to permit the development of health services in all medically underserved areas. Specifically, we ask for inclusion in the Budget of sufficient funds to enact H.R. 1326, which would provide $30 million to assist Community and Migrant health centers combat infant mortality.
- All children should be adequately immunized against all preventable childhood diseases. CDF recommends prompt implementaiton of the national Childhood Vaccine Injury Act in order to better control the price of vaccines, as well as conversion (over the next five years) of the Childhood Immunization Program into an entitlement program.

New goals must be established if the nation is to achieve an acceptable level of improvement in infant and child health. These new goals cannot consist simply of improved health outcomes but also must include the programmatic commitments that can make these goals a reality. And we must recognize that the new expenditures to meet these programmatic commitments should be measured against what they will save the nation over the long term--in money and in human suffering.

PREPARED STATEMENT OF LINDA A. RANDOLPH, M.D., DIRECTOR, OFFICE OF PUBLIC HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH

Let me begin by thanking the Committee for the opportunity to speak here today on behalf of Governor Cuomo and Commissioner Axelrod on this important subject. Infant mortality is one of the most serious public health problems facing our nation today. Yet legislation and programs emerging among the States and coming from the Federal government offer hope of reducing the scandalous level of infant deaths in our land. We are, I believe, headed in the right direction, and I am here today to describe New York State's contribution to our collective effort.

In New York, we have long recognized the importance of prenatal care in promoting healthy birth outcomes and reducing infant mortality. In the late 1970's, we implemented, with Federal assistance, an Improved Pregnancy Outcome (IPO) program, designed to develop statewide data on prenatal and perinatal mortality, on other poor birth outcomes, and on the need for prenatal services. Emphasizing analysis of data by small areas whose health problems are often masked by aggregate county and State statistics, the IPO provided us with a data base that has since enabled us to target prenatal care services to areas and populations in greatest need. Its several demonstration projects helped us to develop protocols for prenatal care services, including the health education and counseling services essential to sound maternal and infant health.

In 1983, we used our Federal Emergency Jobs Bill award to fund 14 projects for Prevention of Low Birthweight through the provision of prenatal care and health education to women at high risk for poor pregnancy outcomes. In that same year, we began operating an Infant Health Assessment Program (IHAP) designed to ensure that babies born at high risk for developmental disabilities and infant mortality received appropriate medical and psychosocial services following hospital discharge. Relying on county public health nurses to locate these infants and connect them to needed care, the IHAP system is the kind of tracking and follow-up system that is essential to any effort to reduce infant mortality.

The major service component of our effort to prevent poor birth outcomes and infant mortality is our Prenatal Care and Nutrition Program (PCNP). Aimed at medically indigent women below 185% of the Federal poverty level, who are ineligible for Medicaid and who have no other third-party coverage, the PCNP provides comprehensive prenatal care services, free of charge, that address the health, social support and education needs of low income pregnant women and their newborns. The program also provides for follow-up of project clients to determine pregnancy outcomes and to ensure adequate postpartum care for both mother and newborn.

Begun in 1985, the PCNP is supported by $18 million in State funds and consists of 89 projects with more than 115 service sites in 43 of the State's 57 counties and New York City. The program has served over 55,000 women since its beginning in January 1985. It now serves 22,000 women annually out of the total 49,000 we estimate to be in need of PCNP services at any one time.

At the same time that we have sought to extend PCNP services to as many pregnant women as possible, we have developed a protocol of services to ensure that the care provided through the program is comprehensive and of high quality. All women participating in the program, for example, receive prenatal services as recommended by the American College of Obstetricians and Gynecologists. All initial prenatal visits include a complete history, physical examination, pelvic examination, laboratory screening, initiation of patient education, screening for nutritional status, and nutrition counseling. Use of a standardized prenatal risk assessment tool occurs at the first visit and is repeated at 26 to 28 weeks. Projects also perform a variety of laboratory tests, including tests for inherited diseases.

Nutrition counseling services are an important component of PCNP services. All women in the PCNP program are screened for nutrition risk conditions. The nutritional risk status of the prenatal client determines the content and frequency of the nutrition intervention provided. Screening for risk status includes: assessment of dietary intake, evaluation of maternal weight status, hematocrit and hemoglobin levels, and a review of the client's chart for health and socio-economic risk conditions. The intervention provided is tailored to the individual women's risk status.

The most common nutrition regimen for PCNP clients is enrollment in the WIC program, for we have found that WIC is the most practical, the most widely available and the best proven means of improving the nutritional status of pregnant women. We have also learned that WIC encourages pregnant women not receiving care to enroll in the PCNP and our other prenatal care programs. Because WIC requires medical documentation of pregnancy status, women applying for WIC prenatal benefits are more likely to be drawn at an early stage into a prenatal care health network. Nearly 53 percent of PCNP women, for example, enter the program through referral from local WIC programs. The remaining 47 percent, who come to PCNP first, are enrolled in WIC as part of their regimen of prenatal care. Clearly, WIC is a good source for entry into prenatal care, just as a well managed program of prenatal care can be an introduction to WIC. Any effort to promote one should also promote the other.

Yet, as this committee knows, funding for WIC has never been sufficient to cover all eligible women, infants and children. In New York State we operate the largest WIC program in the nation, but still serve only about 45 percent of the people who qualify for it. This figure is somewhat misleading. Due to setting priorities, at least 85% of all pregnant women < 185% of poverty level are enrolled in WIC. We are able to achieve this level of participation only by adding to our Federal WIC award the States Supplemental Nutrition Assistance Program (SNAP) funds. We have allocated nearly $31 million in State funds to WIC in our current fiscal year, an amount that will extend WIC to over 50,000 more women, infants, and children than the roughly 240,000 who will be served through USDA funding. But even this combined Federal and State effort, laudable though it is, will not be enough. We must give WIC greater support if we are to reduce infant mortality in our country. I urge the members of this committee to work closely with their colleagues on other Senate and House committees to increase funding for WIC in order to extend the program's benefits to greater numbers of pregnant women, breastfeeding women and infants.

No program of prenatal services, no matter how elaborate or well-planned, will be of benefit if it is not accessible to those who need it most. Last year, the Congress took a significant step in making prenatal care accessible to greater numbers of women when it passed the SOBRA legislation allowing States to extend Medicaid coverage for prenatal care to women with incomes up to 100 percent of the Federal non-farm poverty level. This year, the Congress has another opportunity to make prenatal care more widely available by approving H.R. 1018, the Waxman-Hyde bill, which would permit states to extend Medicaid coverage for prenatal care to women with incomes up to 185 percent of the poverty level. I urge each member of this committee to support this proposed legislation.

As the Congress considers the Waxman-Hyde measure, we in New York State are seeking the State Legislature's approval of a bill to expand prenatal care to a greater number of women than those potentially eligible for our PCNP and other prenatal programs. Called a universal access program, this effort would provide coverage for all women inelgible for Medicaid and other third party support but unable to pay for a full complement of prenatal services. Its purpose is to provide comprehensive prenatal care to those medically indigent and so-called "working poor" women who remain ineligible for Medicaid and yet still cannot obtain coverage from their employer or private carriers. The passage of this bill in our Legislature and of H.R. 1018 in the House and Senate would ensure that no pregnant woman in New York State would go without prenatal care. It is just such complementary Federal-State efforts that are essential to the reduction of infant mortality in our country.

I said at the beginning that we were moving in the right direction in reducing infant mortality. From 1975 to 1985 infant deaths per thousand live births in New York State declined from 16 per thousand to 10.7 per thousand. Nationally, the rate declined from 16.1 per thousand to 10.4 per thousand in the same period. Clearly, the Federal and State efforts I have discussed here--special programs in prenatal care, increased enrollment in WIC, and expanded Medicaid and State fiscal support of services to pregnant women--are having an effect. We know what works. We should not be discouraged by recent data which point to a slower rate in the decline of infant mortality in the past few years. Rather, we should re-double our efforts to gain support for those programs, services and funding mechanisms that, together, will help us rid ourselves of one of our greatest national problems--the untimely death of our infants.

Thank you.

APPENDIX C

PRENATAL CARE PROTOCOL

The following guidelines are based upon the Standards for Obstetrics-Gynecologic Services published by the American College of Obstetricians and Gynecologists (ACOG) in 1985. These are considered minimum standards for prenatal care programs, and should be reflected in submitted applications.

A. Enrollment

Enrollment for prenatal care in the first trimester is an important first step in achieving optimum pregnancy outcome. However, patients seeking care in the second or third trimester must not be turned away. For women at low risk, a minimum schedule of visits must be provided every four weeks until the 28th week, every two weeks until the 36th week, and weekly thereafter until delivery. For women at increased risk, the frequency of visits should be increased and the content of the visits designed to meet clients' needs.

B. Initial Visits

The initial prenatal visit must include a complete history, physical examination, pelvic examination, laboratory screening, initiation of patient education, screening for nutritional status, and nutrition counseling. Use of a standardized prenatal risk assessment tool must occur at the first visit and be repeated at 26-28 weeks.

Initial laboratory studies to be performed, and for which funding is provided, include:

- Pregnancy testing (if needed)
- Hematocrit/Hemoglobin
- Blood group and RH determination
- Irregular antibody screen
- Rubella antibody titre
- Syphilis and Gonorrhea screen
- Urine culture
- cervical-vaginal cytology (PAP)
- Urinalysis

Additional testing may include:

- Tuberculin testing
- Blood glucose test
- Sickle cell and inherited disease screening

Plans to manage abnormalities (i.e., anemia, urinary tract infection) should be promptly initiated. The above studies/testing can be done on site or contracted through outside laboratories.

C. Repeat Visits

Subsequent prenatal visits must include the following components:

1. **History**: Occurrence of headache, changes in vision, dizziness, edema, nausea and vomiting, bleeding, awareness of fetal movements, occurence of contractions or rupture of membranes.

2. **Physical Examination**: Maternal blood pressure, weight, presence of edema, height of fundus (fetal position and heart beat in second half of pregnancy).

3. **Laboratory Tests**: Urine testing for sugar and albumin, repeat Hematocrit or homoglobin at 36 weeks, STDS rescreening and other tests, as medically indicated. Such tests include urine culture, VDRL, and a complete blood count at 27-30 weeks.

4. **Education**: A combination of private interviews with health personnel, group discussions or classes, and printed material in the client's native language. Topics should include:

    - Orientation to facility procedures
    - Rights/responsibilities of the client
    - Signs of complications of pregnancy
    - Exercise, body mechanics, activities during pregnancy
    - Childbirth education
    - Nutrition
    - Sexuality during pregnancy
    - Occupational concerns
    - Smoking/drug/alcohol use
    - Use of medications and drugs
    - Signs of labor
    - Labor and delivery process
    - Obstetrical anesthesia and analgesia
    - Preparation for parenting and parenthood
    - Care of the infant
    - Infant feeding instruction/options
    - Family planning.

D. Nutrition Counseling

Nutrition counseling services are an important component of prenatal care services. The nutritional risk status of the prenatal client will determine the content and frequency of the nutrition intervention provided. All prenatal women should be screened for nutrition risk conditions. Screening for risk status should include: assessment of dietary intake, evaluation of maternal weight status, hematocrit and hemoglobin levels, and a review of the client's chart for health and socio-economic risk conditions. The intervention provided should be tailored to the individual woman's risk status. Clients with moderate or high risk nutrition problems will require more indepth and frequent nutrition interventions to prevent complications of pregnancy and promote optimal nutritional status. A nutritionist or registered dietitian, with prenatal nutrition experience, should be identified to provide nutrition support services.

A description of the methods for providing nutrition services to low, moderate and high risk women should be included in the application. Briefly describe the procedures for nutrition screening, assessment, intervention, documentation and follow-up. Also, identify the staff responsible for providing all nutrition services. Agencies are encouraged to make the appropriate linkages with community food nutrition programs such as WIC, Cooperative Extension, SNAP, EFNEP and Food Stamps. PCNP reimbursement rates include one hour of nutritional counseling over the course of the pregnancy.

E. Psycho-social Support Services

Psycho-social support services are integral to a quality prenatal care program. Screening and follow-up of social, economic and/or emotional problems should be viewed as an ongoing process with the ability to make counseling referrals as needed. A description of how such support services are included in the prenatal program plan should be included on the submitted application.

F. Risk Assessment

Identification of clients at risk should be facilitated by use of a standardized tool. Results of the risk assessment will determine the frequency and content of prenatal visits. Such information from the risk assessment will be utilized to develop an individualized plan of care for each client which is documented in the patient's medical record.

G. Postpartum Visit

The postpartum visit should occur between 4-8 weeks after delivery, depending upon the individual needs of the client.

Postpartum interventions include:

1. Interval history and assessment: Including integration of neonate into the family unit; social, economic, cultural and environmental factors.

2. Physical examination: Assessment of the breasts, blood pressure, abdomen, external and internal genitalia, and weight.

3. Laboratory studies: As indicated including rubella immunization.

4. Family Planning: Offering the client a program of instruction and counseling in family planning, which may include referral to appropriate sources for family planning services as per 10 N.Y.C.R.R. 405.8(a)(10)(iv).

5. Education: (Using a combination of private interviews with health personnel, group discussions or classes, and printed material in the client's native language).

Topics should include:

- o care of the infant, including infant feeding
- o exercise/body mechanics
- o nutrition
- o adaptation to parenting
- o sexual activity
- o occupational concerns

RESPONSES TO QUESTIONS FOR LINDA A. RANDOLPH, M.D.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. From your experience, what type of outreach is necessary to operate an effective Infant Mortality Prevention Program and how important is this component in strategies to reduce infant mortality?

Answer. In our experience, an effective outreach program must focus on: Eliminating perceived/actual barriers to care, disseminating information on the importance and benefits of prenatal care, directing recruitment efforts to targeted populations, forming resource linkages, and follow-up of missed appointments.

We have found that use of outreach workers drawn from the local community is the most effective means of carrying out these several activities. Such persons are readily accepted by women unfamiliar with the health care system or intimidated by language and cultural barriers. They also are apt to know personally or through neighborhood contacts the women in the particular service area who are pregnant and not receiving care. If knowledgeable about the spectrum of health and social services needed by pregnant women, these workers can also guide the women through whatever configuration of such services exists in the local area, in effect serving as health guides and networkers.

We have found further that printed messages are helpful in bringing women into care. Brochures printed in low-literacy English and in appropriate foreign languages are easily disseminated by outreach workers and by churches, neighborhood associations, and other community organizations. Broadcast messages are also effective, but it can be difficult to persuade stations to air them during prime time, when most women in need are apt to be watching television or listening to the radio.

Question. What do you consider to be the Federal barriers to improving local coordination between the WIC, Medicaid, and other public health programs? How is the State of New York working to eliminate these barriers?

Answer. In our experience, there are no barriers as such in Federal regulations or statute to greater coordination between WIC and prenatal care. What is lacking are requirements that local agencies refer pregnant women to locally available, easily accessible prenatal services upon enrollment in the WIC Program; similarly, Medicaid-funded providers of prenatal care not required to refer their clients to WIC services. While such referral processes are encouraged in both programs, they are not specifically demanded as a condition for WIC funding or for Medicaid reimbursement. A more activitist approach is needed.

In New York State we are seeking to strengthen the linkage between WIC and prenatal care by modifying WIC client data forms to include information on where the applicant is obtaining health care—private physician, local community health center, hospital outpatient department, or other source. We have begun a pilot study in four local WIC agencies to test methods of obtaining such information, as well as for developing follow-up mechanisms to ensure that health care continues as the woman receives WIC benefits.

A later phase of the study will test ways of initiating care for expectant women reporting no health care at the time of their enrollment into the WIC Program. Agencies participating in the study will work with their counterparts in local Prenatal Care and Nutrition Program (PCNP) projects to identify, in advance, blocks of time in which prenatal applicants could be automatically scheduled for health care appointments. The WIC agencies will notify these projects as soon as they schedule an applicant for a prenatal care appointment, and a feedback mechanism will be set up to apprise the WIC agency on whether individual appointments were kept. We hope that this collaborative referral and feedback model will prove practical for use by WIC and PCNP Programs throughout the State, and that it will also prove applicable to arrangements between WIC and other providers of prenatal care, including private physicians.

Question. What health care cost savings have been projected in New York as a result of PCNP?

Answer. At this writing we are analyzing data from our PCNP and other prenatal projects to determine the effects of these efforts on low birthweight, on other poor birth outcomes and on infant mortality. We are not examining the specific cost consequences of our programs, but obviously the more these problems are reduced, the greater the savings to the health care system. More to the point, we think that the figures cited in the Institute of Medicine's report, Preventing Low Birthweight are reasonable in terms of the magnitude of savings to be had from programs such as PCNP. That is, a ratio of $3.38 saved in health care costs for every $1 spent on prenatal care is probably a reliable predictor, provided allowances are made for regional variations in costs and for areas with high concentrations of groups at unusually high risk for poor birth outcomes. I would also emphasize that there are other savings to be gained from preventing those poor birth outcomes that lead to developmental disabilities requiring special educational and psychosocial support services in infancy, early childhood, and sometimes throughout life. More important than cost savings, however, is the reduction in human suffering that occurs as the result of time receipt of prenatal care by women at risk of bearing a low-birthweight child.

Question. What types of targetting mechanisms do you have for bringing residents of high infant mortality areas into crucial nutrition and health care programs?

Answer. Prenatal Care and Nutrition Programs finds are awarded to applicants in areas with high rates of low-birthweight and infant mortality and with large numbers of households headed by females living at or below 185 percent of the Federal poverty level. The Department of Health has complied information on such indicators for the entire State, breaking them down by minor civil division, census tract, and other relevant geographic areas. Applicants proposing to serve such areas must show that they are able to attract women at high risk for poor birth outcomes. and that their clinic personnel can serve the special needs of these women.

Question. How adequate are the numbers of types of physicians in low-income communities who participate in the Medicaid Program?

Answer. Like most other States, we have a problem obtaining adequate numbers of physicians to serve Medicaid clients. In many instances, this reflects the medically underserved nature of the area itself rather than problems with physician participation in Medicaid. We have found National Health Service Corps and State regents scholarship physicians helpful in such locations, but recognize that use of such personnel is not a long-term solution to the shortage of physicians for low-income women and infants. We have encouraged the use of certified nurse midwives in these and other areas, but have found that the statutorily required physician supervision of such personnel can be hard to obtain.

In parts of the State that have adequate number of physicians, we have sometimes found a reluctance on the part of obstetricians to accept Medicaid clients because of the low-fee schedule and, perhaps more frequently, because of concern that treatment of people at the lower end of the socioeconomic scale may drive away more affluent clients. We thus find that we are apt to reach more women in need by supporting service providers that employ salaried staff physicians than we are by relying upon doctors concerned about generating revenues sufficient to support a private practice.

PREPARED STATEMENT OF J. MICHAEL McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, it is a pleasure to appear before you today to discuss the Department's initiatives in infant and maternal health nutrition. We appreciate the leadership that your committee has shown in identifying important areas of maternal and infant health.

I would like to share with you efforts that the Department has undertaken towards improving the health and nutritional status of infants and children. We are particularly concerned about those segments of our population who do not have access to established health care systems. For this vulnerable group we have adopted several specific outreach programs and are working closely with the USDA to help ensure increased coordination of Federal food assistance programs and DHHS Maternal and Child Health Programs.

The death of an infant is a personal tragedy and a loss to the Nation. Each year, approximately 40,000 United States infants die before reaching their first birthday. Infant mortality rates, defined as the number of infant deaths under one year per 1,000 live births, are viewed worldwide as an indicator of a nation's overall health status.

Historical Trends

Our progress in reducing overall infant mortality in this Nation has been considerable. Our infant mortality rate has declined steadily throughout the entire course of this century. In 1900, more than 100 babies out of every 1000 that were born alive never reached their first birthday. Due to nationwide improvements in nutrition, in control of infectious disease, and in health care, the rate fell to 14.1 by 1977. By 1984, the last year for which final data are available, the rate was 10.8 per 1000. Our best information is that the rate is still dropping. Provisional data for 1986 show a rate of 10.4 per 1000.

And improvements in infant survival have occurred among all racial groups in our society. Since 1978, the infant mortality rate among whites has fallen from 12.0 to 9.4 per 1000. For Native Americans, the rate was 13.7 per 1000 in 1978; it is now 9.5 per 1000, a drop of 31 percent in less than 10 years. For black Americans, the rate in 1978 was 23.1 per 1000; it has declined at the same rate as the other racial groups to 18.4 per 1000. Of great concern to this Department is that the rate for black Americans remains nearly twice that for whites. As I shall discuss shortly, major Departmental initiatives have been designed to address this problem directly.

The Role of Low Birthweight in Infant Mortality

The most important factor contributing to the infant mortality rate in the United States is low birthweight, defined as a birthweight of less than 2,500 grams, or five and one-half pounds. Low birthweight is a result of premature birth prior to 37 weeks gestation, to intrauterine growth retardation, or to both. Research has demonstrated that the risk of mortality increases as birthweight decreases. It is those tiniest of babies who weigh less than 1,500 grams who are at greatest risk.

Because of improvements in neonatal intensive care, this country has the best record for saving the lives of very small babies. Although less than 7 percent of infants are born with weights below 2,500 grams, such infants account for about two-thirds of all infant deaths. The highest infant mortality rates are observed in black mothers, teenage mothers, and mothers of low educational status. Their high risk is largely explained by the fact that they give birth to more very small infants. Low birthweight babies are at high risk for a wide variety of serious illnesses, among them developmental handicaps, birth defects, respiratory and other infectious diseases, behavior problems, and complications of medical interventions. These conditions greatly increase the emotional and financial burden to the infant's family and to the Nation's health care costs.

Although rates of infant mortality have greatly decreased, those for low birthweight have posed a much more serious challenge. For the Nation, the proportion of low birthweight infants dropped from 7.6 percent of live births in 1971 to 6.8 percent in 1981. This situation emphasizes the need to develop effective intervention strategies based on controlling behavioral risk factors.

Risk Factors for Infant Mortality

The lack of certain medical, social and behavioral, and dietary factors increases a mother's risk of giving birth to a low birthweight infant.

Medical risk factors during pregnancy include low prepregnancy weight; inadequate weight gain; chronic illnesses such as diabetes, gastrointestinal disorders, hypertension, or toxemia; and a previous reproductive history that includes many pregnancies, anemia, toxemia, inadequate weight gain, or low infant birthweight.

Social and behavioral risk factors have been identified as low socioeconomic status, poor educational level, race, single marital status, adolescence, poor prenatal care, and use of drugs, alcohol, or cigarettes.

Dietary risk factors include inadequate intake of calories which leads to inadequate weight gain, or insufficient intake of nutrients such as iron, folate, zinc, or calcium, leading to malnutrition.

Research has shown that the more of these factors present, the greater the risk to mother and infant. Many of these factors are especially prominent in blacks and other groups at greatest risk of delivering low birthweight babies. Black women, for example, are most likely to have a teenage birth, an out-of-wedlock or high parity birth, to be of low socioeconomic status, and to have poor health care during and after pregnancy.

Although some of these risk factors are innate, acquired, or accidental, most of them are subject to personal or societal intervention. Cessation of drug usage and cigarette smoking are obvious examples, as is improved prenatal care. Of special interest to our discussion today are those risk factors related to nutrition: low prepregnancy weight, inadequate maternal weight gain during pregnancy, anemia, excessive alcohol consumption, and inadequte nutrient or energy intake. Nutritional factors are also important in control of symptoms of diabetes, hypertension, and gastrointestinal disorders when such conditions are present.

So it is evident that nutrition is extremely important during pregnancy. Well-nourished mothers who gain appropriate amounts of weight during pregnancy give birth to heavier and healthier babies. A poorly-nourished mother who eats well and gains enough weight during pregnancy can greatly improve her chance of giving birth to a healthy child. And we all know how important good nutrition is for infants during their crucial first year of life.

Research has demonstrated repeatedly that nutrition intervention improves the outcome of pregnancy. Increasing the food intake of malnourished mothers raises the birthweight of their infants significantly. And the greatest gains are observed among infants of the most severely malnourished mothers.

Public Health Service Initiatives

I would now like to turn to the activities of our Department that are directed toward prevention of low infant birthweight and excessive infant mortality. These prevention targets have been a major focus of Public Health Service efforts since publication of Healthy People: The Surgeon General's

Report on Health Promotion and Disease Prevention in 1979. This report identified five broad goals related to improvements in health status. The first of these goals was a 35 percent reduction in infant mortality by the year 1990, with prevention of low birthweight and birth defects its special areas of focus.

Because identification of the goal is only the initial step in the process of improving health outcome, Healthy People specified 15 target areas for health promotion and health protection activities and preventive health services designed to promote achievement of the goals. Pregnancy and infant care was designated as one of these target areas. In addition, several others--improved nutrition, alcohol and drug abuse reduction, smoking cessation, toxic agent control, accidental injury control, and immunizations--also were designed to benefit the health of mothers and infants.

These 15 areas were then the focus of an 18-month follow-up effort to develop specific and measurable objectives for the Nation to be achieved by the year 1990. The results of this intense activity were published as Promoting Health/Preventing Disease: Objectives for the Nation which identified 226 objectives in the 15 priority areas. The Pregnancy and Infant Health area contained 19 objectives designed to improve the health of mothers and infants. In addition, four objectives in the Nutrition area, and one in the Alcohol area, were relevant to this health goal.

We have just completed the Midcourse Review of the progress of these objectives. Although many of the results of this review provide cause for optimism about the health of the Nation, there are several in the Maternal and Infant Health area that offer cause for concern.

The 1990 Health Objectives for Reduction of Infant Mortality and Low Birthweight

At this point, I would like to review our progress toward achievement by 1990 of several selected health objectives directly related to lowering infant mortality and low birthweight or to improve nutrition or nutrition counseling.

- By 1990, the national infant mortality rate should be reduced to no more than 9 deaths per 1000 live births.

We can report considerable overall progress in this area. The 1978 infant mortality rate was 13.8 per 1000 live births, and the latest provisional data indicate 10.4 deaths per 1000 live births. This provisional figure represents a 1.9 percent reduction from the 1985 provisional rate. The overall provisional rates for 1983-86 indicate a slowdown in the rate of decline experienced from 1970-82, but they are more encouraging than data from September-November 1986 which suggest that the infant mortality rate has reached a plateau. Several more months of provisional data, as well as 1985 final data, will be required before conclusions can be drawn.

- By 1990, no county and no racial or ethnic group of the population should have an infant mortality rate in excess of 12 deaths per 1,000 live births.

In 1984, the rate for whites was 9.4 per 1000 live births, and the rate for blacks was 18.4 per 1000 live births. The infant mortality rate for blacks is declining at the same rate as for whites and it is unlikely that this objective will be met.

- By 1990, low birthweight babies (2,500 grams and under) should constitute no more than five percent of all live births.

The proportion of low birthweight has decreased from 7.1 percent in 1978 to 6.7 percent in 1984. The Department has mounted several initiatives that will continue the progress that has been made in this area. A major program has been developed by the Secretary to inform women of the hazards of smoking during pregnancy. In addition, a Low Birth Weight Prevention Work Group has been established through the Assistant Secretary for Health that will analyze and recommend options for reducing the incidence of low birthweight, and research continues at NIH's Institute on Child Health and Human Development to determine the etiology of low birthweight.

- By 1990, no county and no racial or ethnic groups of the population (e.g., Black, Hispanic, American Indian) should have a rate of low birthweight infants that exceeds nine percent of all live births.

In 1984, all ethnic and racial groups except blacks had a low birthweight below 9 percent. To meet this objective for the black population, the challenge will be to identify means for control of major risk factors.

A significant number of State and national organizations have initiated educational programs targeted to pregnant women on these subjects. Data from the National Center for Health Statistics 1980 National Natality Survey and 1980 National Fetal Mortality Survey, indicate that once a woman discovers she is pregnant, she will reduce smoking and drinking habits. For example, between 1967 and 1980 the percent of married mothers over 20 years of age who smoked during pregnancy declined by 13 percent for women with less than 12 years of education, by 22 percent for women with 12 years of education, and by 55 percent for women with more than 12 years of education. The proportion of married mothers under 20 years of age who smoked during pregnancy did not change significantly between 1967 and 1980. The growing number of State and local efforts in this area suggest that there will be continued progress toward achieving this objective.

- By 1990, the proportion of women who breastfeed their babies should be increased to 75 percent at hospital discharge and 35 percent at six months of age.

This objective may be achieved if current trends continue. In 1978, the proportion was 45 percent at hospital discharge and 21 percent at 6 months of age. In 1984, the proportion was 61 percent at discharge and 27.5 percent at 6 months. More recent trends, however, suggest some slowing down of this trend since 1982. Of special concern is the low rate of breastfeeding among black and poorly educated mothers. We are continuing to monitor breastfeeding patterns among the disadvantaged populations, particularly among black and less educated women, and note that there is now a USDA study on ways to increase the emphasis on breastfeeding in WIC nutrition education programs.

- By 1990, the proportion of pregnant women with iron deficiency anemia (as estimated by hemoglobin concentrations early in pregnancy) should be reduced to 3.5 percent.

In 1978, the proportion of pregnant women with iron deficiency anemia was 7.7 percent. Federal maternal and child health programs have substantially increased services and training to improve nutrition and health for pregnant women, infants, and children and most include some emphasis on iron nutrition. Available data from the WIC program of USDA and State Maternal and Child Health programs suggest progress in communicating information to the public about the prevention of iron deficiency anemia, and some research has reported beneficial effects on hemoglobin levels in children enrolled in WIC programs. To a certain extent, progress in achieving this objective is difficult to evaluate because data available are from a voluntary reporting system rather than from a national sample survey. However, the 1988 National Maternal and Infant Health Survey will provide a means to monitor progress in this area in the future.

- By 1990, growth retardation of infants and children caused by inadequate diets should have been eliminated in the United States as a public health problem.

In 1983, data show that linear growth retardation remains at levels ranging from 10.9 to 23.9 percent in select groups of low income children. Although recent CDC data from 1979-83 indicate some decrease in rates of short stature among Hispanic and Asian American children, it is unlikely that this objective will be met.

- By 1990, virtually all routine health contacts with health professionals should include some element of nutrition education and nutrition counseling.

Although data on a representative nationwide sample of health professionals are not available, provisional data from the 1985 National Health Interview Survey do provide some sense of developments in this important area: 22 percent of male and 29 percent of female patients report that their health care provider discusses dietary issues with them.

- By 1990, virtually all women and infants should be served at levels appropriate to their need by a regionalized system of primary, secondary, and tertiary care for prenatal, maternal, and perinatal health services.

In 1979, approximately 12 percent of births occurred in areas served by such a system and these areas report substantial increases in utilization of centralized services for delivery and care of high-risk infants, but insufficient data are available to define and measure the effectiveness of regionalization. Additional factors contributing to lack of progress on this objective are maldistribution of medical care providers, lack of outreach and educational efforts, and economic factors such as lack of third-party health care coverage.

- By 1990, the proportion of women in any county or racial or ethnic group (for example, Black, Hispanic, American Indian) who obtain no prenatal care during the first trimester of pregnancy should not exceed 10 percent.

In 1978, 22 percent of White mothers, 40 percent of Black mothers, 44 percent of American Indian mothers, and 43 percent of Hispanic mothers received no prenatal care during the first trimester. In 1984, these percentages were reduced slightly to 20 percent of White mothers, 38 percent of Black mothers, 40 percent of American Indian mothers, and 38.5 percent of Hispanic mothers. Based on progress to date, it appears unlikely that this objective will be met. Four States are expected to achieve the goal for White women, but none is expected to meet or exceed the goal for minority women, and the percentage of Black women who receive early prenatal care actually declined slightly from 1980 to 1982. Rates of early prenatal care are especially low among teenage mothers. In 1982, about 53 percent of black pregnant teenagers and 42 percent of while pregnant teenagers failed to obtain care in the first trimester. This lack of early care has been attributed to high costs, lack of care providers, inadequate services, poorly located sites for care, and systematic inadequacies in recruiting hard-to-reach women.

Other relevant objectives cover reductions in neonatal and perinatal death rates, maternal mortality rates, neural tube defects, fetal alcohol syndrome, and improved food selection by pregnant women. Progress toward achievement of these objectives has been variable.

Current DHHS Activities

The Department is firmly committed to programs aimed at reducing infant mortality and low birthweight. I would like to take this opportunity to review some of these programs with you.

- Recent Expansions in Medicaid Eligibility of Pregnant Women and Children. Recent legislative initiatives have expanded Medicaid eligibility of pregnant women and children. For pregnant women, the Consolidated Budget Reconciliation Act (COBRA) of 1985 extended eligibility to all pregnant women in two-parent families that meet State AFDC income and resource standards regardless of the employment status of the principal breadwinner. The Omnibus Budget Reconciliation Act (OBRA) of 1986 created a new eligibility option for pregnant women (through 60 days following pregnancy) with family incomes up to the Federal poverty level. To assure continuity of eligibility, pregnant women eligible under the OBRA provision are eligible throughout the pregnancy regardless of changes in family income. Barriers to the timely and appropriate receipt of prenatal services are avoided by an OBRA provision making ambulatory prenatal care services immediately available to pregnant women during a special presumptive eligibility period. For infants and children, OBRA created a group of optionally eligible infants up to one year of age. Beginning in FY 1988 States can increase the age level of eligible children by one year each fiscal year until all children up to the age of five are included.
- The Secretary's Initiative. The Secretary proposes to create a special demonstration program under Medicaid to test the effectiveness of providing case-managed, comprehensive services--educational, nutritional, and medical--for pregnant women (including teenagers) who are at high risk and who may have low birthweight babies. We will give priority to States that can demonstrate effective and imaginative approaches to the problem. These demonstration projects will be coordinated with the delivery of services throughout other Federal

programs and will supplement ongoing efforts under the Maternal and Child Health Block Grant.

- PHS Low Birth Weight Prevention Work Group. This group was established in March 1984 by the Assistant Secretary for Health in order to develop cohesive strategies for reducing the number of low birthweight infants and the infant mortality rate, and for improving the health of newborns. The Work Group is co-chaired by the Director of the Division of Maternal and Child Health (DMCH), Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, and the Director of the National Institute of Child Health and Human Development (NICHD), National Institutes of Health. Work group members are personnel with maternal and child health expertise and key responsibilities within the PHS Agencies and the Health Care Financing Administration. The Work Group has, through the sponsorship of the DMCH and NICHD, formed the PHS Expert Panel on the "Content of Prenatal Care." Since prenatal care is a key factor in the prevention of infant mortality, the potential impact of this Panel's analysis and recommendations is of great significance.
- The Maternal and Child Health (MCH) Services Block Grant authorizes annual appropriations for allocation to States and other jurisdictions and provides them with funds to allocate resources based upon their own needs assessments and priorities in order to assure access to maternal health services of good quality and to reduce infant mortality--especially by providing prenatal care and preventive services. In addition, this MCH program funds State programs to improve health status outcomes for mothers and children.

- Grants for Special Projects of Regional and National Significance (SPRANS) are funded by DMCH to improve health status outcomes for mothers and children. They have been awarded for projects focused on pregnancy and infant care that were designed to target gaps in the service system and to improve services to high risk populations. The projects emphasize tracking mechanisms, low birth weight prevention, and mechanisms for delivering services in rural areas, reduction of postneonatal mortality, and promotion of early and continuous prenatal care.
- The National Health Services Corps (NHSC) is placing obstetricians and pediatricians in positions where they can provide direct services in medically underserved areas.
- Community Health Centers (CHC) and Migrant Health Projects provide prenatal care to medically underserved pregnant women. They include a perinatal initiative to ensure delivery of high quality maternal and infant health services. Recent activities include publication and promotion of guidance materials for development of perinatal services in community health centers and stimulation of the development of service systems in rural areas.
- The Indian Health Service, working with tribal health departments, private practitioners, and national professional organizations, provides comprehensive maternal and child health services, with emphasis on early identification of pregnant women and entrance to care, especially for the teenage population. Additional emphasis is on regionalization of perinatal care to assure appropriate access and to the prevention of fetal alcohol syndrome and its effects. Over the past decade, the improvement in infant mortality rates for Native

Americans has been proportionally greater than for blacks, whites, or the United States population as a whole.

- The National Institute of Child Health and Human Development (NICHD). Among the many relevant activities of this Institute is a special research initiative focused on the prevention of low birthweight. This initiative is a multi-faceted research undertaking with seven primary emphasis areas relating to prematurity and intrauterine growth retardation. It includes the development of Maternal-Fetal Medicine and Neonatal Intensive Care Units that will use common protocols to examine important clinical methods of prevention of low birthweight.
- A National Infant Mortality Surveillance Conference was jointly sponsored in May 1986 by the Centers for Disease Control (CDC) and other Department agencies to establish measures of survival likelihood for specific birthweight categories, for each State, and for the Nation as a whole. Papers from the conference are presented in the March/April issue of Public Health Reports.
- CDC Severe Pediatric Malnutrition Surveillance Study. In response to a Congressional mandate to assess the feasibility of developing a hospital-based system for identifying cases of severe undernutrition among low income, high-risk children, the CDC will establish pilot projects in two or more States. Efforts will be made to assist States to develop and evaluate the feasibility of a population-based surveillance system (including hospital sources of cases) which identifies children with severe undernutrition; to collect and analyze information on prevalences, etiologies, and risk factors; and to facilitate appropriate intervention for cases of children who are identifed as being severely undernourished. Notices will appear in the Federal Register within the next few weeks.

- CDC Surveys of Pediatric and Maternal Malnutrition. The CDC sponsors several State and local surveys of maternal and infant malnutrition aimed at prevenion of morbidity and mortality in these groups. These include two collaborative surveys with universities in Minnesota and Washington, D.C., the Pediatric Nutrition Surveillance System in 34 States, the District of Columbia, and Puerto Rico, and State-based Surveillance Systems in 19 States. A low income monitoring study, now underway, describes and assesses DHHS efforts to monitor the nutritional status of low income populations. It is scheduled for completion in July 1987. Of special interest to this committee are high-risk pregnant and lactating women, and children under five years of age. Other vulnerable groups includes school-age children, adolescents, adults, nursing home residents, other elderly, Native Americans on reservations, and the homeless.
- Family Service Administration Activities. Outside the Public Health Service, the Family Support Administration (FSA) established a Teen Pregnancy Prevention Task Force in June 1986. The Task Force will assist community service groups such as the National Urban League, Girl Scouts and Boy Scouts in developing agendas that address this problem at the local level. To assist in this effort, the FSA is developing a clearinghouse that provides funding and resource information on community services block grants, human services block grants, and discretionary funds that can be used to establish programs at the State and local levels. The Clearinghouse will also provide resources on the activities of other organizations and will work with the Children's Defense Fund and the National Urban League to produce media campaigns on this topic.

Interdepartmental Cooperation Between DHHS and USDA

The Department is aware that strong linkages between maternal and child health programs and food assistance programs of the Department of Agriculture are critical in order to reach women who, because of either health or income factors, are at highest risk for delivering low birthweight babies. This coordination can be found at every level from the Department down to the local WIC and MCH offices. The following examples are illustrative of this cooperation in the areas of education, research and service provision:

- MCH-WIC Coordination. Last year, a special study was undertaken through the Assistant Secretary for Planning and Evaluation to identify the relationship between the Maternal and Child Health Program (MCH) and the Special Supplemental Food Program for Women, Infant and Children (WIC) and to identify ways to coordinate these efforts at the Federal, regional, State, and local levels. Technical advice was provided by the USDA. The report focused on case studies that demonstrated how coordination can be accomplished within different administrative structures and it presented recommendations for achievement of such coordination nationwide. The report highlighted the importance of coordinated facilities at the local service level, and the use of common clinical standards, nutrition education materials and eligibility criteria to facilitate service delivery. Regional staff work with States to enhance coordination at the local level. DHHS is represented on the National Advisory Council on Maternal, Infant, and Fetal Health, administered by the Food and Nutrition Service, USDA. In addition, staff of the Health Resources and Services Administration currently sit on USDA Technical Advisory Committees to oversee progress on two grants examining the WIC program; one on WIC and Breastfeeding and the other on development of a Good Practices Manual for WIC programs. Finally, the USDA has designated a WIC liaison representative to work with the MCH Coordinator at the regional level. As a result, USDA and DHHS MCH/WIC staff members meet formally on a regular basis to share information and to develop collaborative efforts to improve MCH/WIC programs.

- USDA/DHHS Nutrition Education Committee for Maternal and Child Nutrition Publications. Since it was established in 1980, this interdepartmental committee has been actively promoting collaboration between USDA and DHHS on the development of educational materials related to maternal and child nutrition. The committee seeks to assure consistency of content, avoid duplication, and make more effective use of resources. Over the past year, the committee has been instrumental in the preparation of two publications: Cross-Cultural Counseling: A Guide for Nutrition and Health Counselors, for counselors who serve the Hispanic American, Native American, Black American and Asian-Pacific American populations; and Nutrition and Adolescent Pregnancy: A Selected Annotated Bibliography, which provides technical assistance to health care providers, educators and others concerned with the health of teenage mothers and their infants.
- The National Maternal and Infant Health Survey has support from USDA and will be initiated in 1988. This survey, administered through the National Center for Health Statistics will collect information for three national samples of vital records: 10,000 certificates of live births, 5,000 death certificates for infants and 4,000 reports of fetal death. A pilot project is underway now and data collection will be completed in 1989. This survey is of special interest as information

on WIC program participation, maternal nutrition habits, and prior reproductive history will be gathered simultaneously for the first time.

- Joint Nutrition Monitoring. The two Departments have collaborated in the publication of the first comprehensive report on the dietary and nutritional status of the U.S. population--Nutrition Monitoring in the United States: A Report from the Joint Nutrition Monitoring Evaluation Committee, which was published in July 1984. This collaboration continues on preparation of the second report which is due to be completed in 1989.
- The Interagency Committee for Human Nutrition Research, chaired jointly by the Assistant secretary for Health and the Assistant Secretary for Science and Education, USDA is comprised of those agencies funding the majority of the Federal nutrition research effort. It provides a framweork for interagency research planning, collaborative research and effective information transfer.
- Joint Cooperative Agreements. Along with the Centers for Disease Control, the USDA has contributed funds to develop three cooperative agreements with States that will examine the relationship between smoking cessation and pregnancy outcome in high-risk, low-income women. Previous studies have shown that programs geared toward pregnant women can help women to stop smoking and result in a lower percentage of low birth weight infants. The USDA is participating in the funding of these projects.

Mr. Chairman, we share your commitment to reducing the remaining excess levels of infant mortality in our high-risk groups. Concerted efforts are underway throughout the Department to investigate the causes of infant mortality and to seek the best methods of eliminating them. Our cooperation with the Department of Agriculture continues, and indeed has probably never been stronger in this area.

Thank you for the opportunity to speak with you today.

Responses to Questions for J. Michael McGinnis, M.D.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Please specify how the Secretary's Initiative, which you briefly discussed in your testimony, will improve the availability and use of prenatal care services for hard-to-reach populations.

Answer. The Secretary's Initiative is designed to improve utilization of prenatal care by the Medicaid population, a group that has traditionally suffered from fragmentation and poor coordination of services, limited coverage, and a lack of individually tailored interventions. It is expected that demonstration projects will include an outreach program to inform women of the need to obtain care early in pregnancy, as well as to publicize the resources for care under the Medicaid Program. These programs may include such elements as culturally appropriate media campaigns, community programs, lay outreach workers, and pregnancy hotlines. Moreover, the case management services, the critical element of the demonstration design, will function to monitor receipt of care, facilitate access to necessary services, and reduce barriers to care, such as transportation and child care needs, for those women enrolled in the projects.

Question. Dr. Hutchins reported that between 10 and 20 States will expand Medicaid coverage as provided for in the last year's reconciliation bill. What incentives are you currently providing or do you plan to provide to encourage additional States to expand this health coverage?

Answer. Although the election of options available under Medicaid is determined at the discretion of individual States, the Division of Maternal and Child Health (DMCH) is focusing on several activities to promote awareness about financing issues for medically indigent women and children. A joint project of the National Governors' Association and the Bureau of Health Care Delivery and Assistance's Divisions of Primary Care Services and Maternal and Child Health has been undertaken which will provide assistance to States in decision-making and implementation of the expanded eligibility and coverage options available under the Omnibus Budget Reconciliation Act of 1986. National and regional meetings to share State experiences and facilitate integration of new Medicaid services are being planned or have been implemented in recent months. In addition, the DMC has provided technical assistance to the MCH/Medicaid Programs in four States (New Jersey, Kansas, Texas, Iowa) in fiscal year 1987.

Question. As you explained in your testimony, there are many demonstration programs to improve infant health which are funded through the discretionary setaside of Maternal and Child Health Block Grant. How do you plan to assure the replication of successful models?

Answer. The DMCH has adopted a number of approaches to encourage the replication and institutionalization of the model projects. Review criteria for grant approvals stipulate that applications include a plan and resources to share information about project development and outcomes with local, State, regional, and national groups; to accomplish this, project staff may provide presentations at conferences, publish manuals or workbooks, and develop articles for relevant journals. A compendium of abstracts, detailing project goals and activities, is published and disseminated annually to promote goals and activities, is published and disseminated annually to promote goals and activities, is published and disseminated annually to promote discussion and networking among the maternal and child health community. In the fiscal year 1987 grant cycle, a special category of incentive grants was created to allow States to integrate model services proven to be efficacious through demonstration projects into their permanent program structure. The priority area for this first year of incentive grants is injury prevention, a strategy that has excellent potential to impact infant mortality rates.

Question. Legislation reauthorizing the WIC Program through fiscal year 1989 requires State WIC agencies to document plans to enroll eligible women in the early months of pregnancy and to provide program outreach to potentially eligible persons most in need. What is DHHS planing to do in cooperations with USDA to assure coordinated and effective outreach to high-risk women and infants?

Answer. Because WIC and MCH are normally administerd through State health agencies, with WIC usually placed organizationally within or paralled to MCH, there is a tradition of reciprocal referrals between the two programs. Early enrollment in care of high risk pregnant women and infants is a priority of MCH programs in efforts to reduce preterm and low birthweight infants and infant mortality. In 1986, DHHS through the Office of the Assistant Secretary for Planning and Evaluation, completed a study to explore, in cooperation with USDA, ways of improving the coordination of MCH and WIC programs. The report, Improving MCH/WIC Coordination, contains a "Good Practices Guide," using case studies of 8 States, which suggests ways coordination can be achieved within different administrative structures. This report has been disseminated widely to both MCH and WIC programs with a cover letter encouraging these programs to use the report as a catalyst for ongoing coordination activities.

DHHS has two representatives on USDA's National Advisory Council on Maternal, Infant, and Fetal Nutrition. In the 10 PHS Regional Offices the Regional Nutrition Consultants in the MCH Programs are designated as the DHHS liaison contact persons with the WIC staff in the USDA regional offices to work with States to facilitate MCH and WIC coordination. For example, in Region IV collaboration between DHHS and USDA has resulted in joint consultation visits to two states. In June 1987, a combined reviews of both the MCH and WIC programs in the States of Alabama was conducted by DHHS and USDA staffs to assist the Commissioner of Health and the Director of MCH in improving the accessibility, availability, and quality of services for mothers and children. In January 1986, a joint MCH/WIC consultation visit was made to Florida to assist the State in its efforts to integrate WIC and nutrition services with related health services. Such efforts have been considered effective in enhancing MCH/WIC coordination.

Question. How are you working with nonhealth division of DHHS to reduce infant mortality rates in poor communities?

Answer. The Secretary's Initiative, discussed in the testimony, has forged a stronger link between the DMCH and the Health Care Financing Administration (HCFA) as staff have worked to coordinate effort and resources to improve the health status of infants in the Medicaid-eligible population group. From this shared activity, the DMCH and HCFA have continued to work together and with representatives from their respective State agencies in the Medicaid/Maternal and Child Health Technical Advisory Group. This group of State program representatives has been working over the past several months on the development of perinatal care standards and model practice relationships between State Agencies to improve the quality and coordination of services to medically indigent women and infants throughout the country.

The DMCH also works collaboratively with the Head Start Bureau in the Office of Human Development Services, along with HCFA, and the Department of Education, to provide guidance to States in the implementation of Public Law 99-457. This law was passed in 1987 and provides for early intervention services for disabled and at-risk infants to promote optimal health.

Question. How does the DHHS evaluate the effectiveness of State programs funded through the MCH Block Grant?

Answer. There is no direct Federal review of the effectiveness of these programs. The Block Grant Program is characterized by the allocation of funds to States with States having the flexibility to apply funds to the health and related priorities they identify as most urgent within their jurisdictions. States address these priorities in both their annual plan or report of intended expenditures and their annual progress reports. Although there are some defined national priorities such as infant mortality and improved services for children with special health care needs, and all States dedicate some resources to these, there are no specific goals set for States by the administering Federal agency. The considerable Federal funds and required State matching involved annually under title V provide a major resource for State programs for mothers, infants, children, and children with special health care needs.

The philosophy of the block grant is based upon assumption of full responsibility by States—including evaluation responsibility. Through public knowledge and participation and through audits conducted on State initiative, as well as other means, Block Grant Program efforts are assessed at the State level. No national appraisal has been carried out since the 1984 General Accounting Office report on the Maternal and child Health Block Grant.

Question. The National Center for Health Statistics has recently reported that adequate maternal weight gain plans a very important role in preventing low birthweight, especially for teenagers and other high-risk groups. What new policies have been implemented as a result of these findings?

Answer. From 1966 to 1970 the Children's Bureau, forerunner of the DMCH, supported a study by the Food and Nutrition Board/National Academy of Sciences on Maternal Nutriction and the Course of Pregnancy. The study report called attention to the strong positive association between the total weight gain of the mother and the birth weight of the infant. As a result of this landmark study, recommendations for weight gain during pregnancy were revised from 10–14 pounds to 20–25 pounds. In recent years, several studies have indicated that further revision of prenatal weight gain recommendations may be appropriate. The National Center for Health Statistics' report, Maternal Weight Gain and the Outcome of Pregnancy, as well as other recent reports by Pedro Rosso (American Journal of Clinical Nutrition, March 1985), Judith Brown (Journal of The American Dietetic Association December 1986), Bonnie Worthington-Roberts (Journal of Nutrition Education, February 1987), and Lisa Meserole (Journal of Adolescent Health Care, January 1984), suggest different recommendations for weight gain during pregnancy. In order to reach consensus on guidelines for optimal prenatal weight gain for women with different risk factors, for example underweight, overweight, and adolescents, and to resolve other maternal nutrition issues that have emerged since the last study was published, the DHHS now was plans to support another such study over the next 3 years. The findings of this study will provide the basis for new recommendations which will be widely disseminated.

Question. What infant mortality reduction strategies has the Department initiated for reducing the black infant mortality rate?

Answer. Many of the Department's infant mortality reduction efforts will affect the black infant subgroup through attention to at-risk populations. For example, demonstration grants awarded by the DMCH serve the black population and other minorities, as a result of the grant requirement to target groups with the most urgent health and service needs. In one funding category, the DMCH is sponsoring seven grants to States, located primarily in the Southeast, to initiate newborn screening programs to identify infants with hemoglobinopathies, including sickle cell disease. Recent research has shown that prophylactic penicillin therapy reduces illness and mortality in children with sickle cell anemia who are identified and followed early in life. To improve our understanding of the individual needs of minority groups and tailor services accordingly, the DMCH and the National Institute of Child Helth and Human Development are cosponsoring research regarding ethnic differences related to pregnancy behaviors. In addition, members of a Public Health Service interagency work group and staff members at Meharry Medical College are in the preliminary stages of studying a cohort of black families for socioeconomic and intergenerational effects on birthweight. The CDC is initiating a cooperative agreement with Morehouse University to do a similar study. Currently the Office of Minority Health is carrying out an inventory of Department activities related to low birthweight and infant mortality.

Among future strategies, the $85 million case-managed Preantal Care Demonstration Program included in the DHHS fiscal year 1988 budget has particular significance for black women. Targeted to Medicaid-eligible populations, a large number of black women and infants in poverty will be reached through this activity. If the case management approach proves successful, its subsequent widespread application will have great significance for black women and infants.

Question. In discussing the midcourse assessment of the 1990 goals, you mentioned that approximately four of the infant health objectives lack sufficient data to provide information on what the status of these objectives will be in 1990. Please specify the four objectives and detail what steps the Department plans to move closer to the prescribed goals.

Answer. There are three objectives in the pregnancy and infant health priority area for which there are no current sources of national data. These are:

By 1990, 85 percent of women of child-bearing age should be able to choose foods wisely (state special nutritional needs of pregnancy) and understand the hazards of smoking, alcohol, pharmaceutical products, and other drugs during pregnancy and lactation.

By 1990, virtually all women and infants should be served at levels appropriate to their need by a regionalized system of primary, secondary and tertiary care for prenatal, maternal, and perinatal health services.

By 1990, virtually all infants should be able to participate in primary health care that includes well child care; growth and development assessment; immunization; screening, diagnosis and treatment for conditions requiring services; and appropriate counseling regarding nutrition, automobile safety, and prevention of other accidents such as poisonings.

Despite our lack of data to measure progress in these areas, the DHHS has undertaken initiatives directed to achievement of these goals. For instance, funding priorities in fiscal year 1987 under DMCH special projects of regional and national significance target demonstration projects aimed at primary care services for children as well as projects to improve systems of regionalized perinatal services in State and local areas. Through the Healthy Mothers, Healthy Babies Coalition, in conjunction with the Alcohol, Drug Abuse and Mental Health Administration, a packet on substance use in pregnancy was disseminated nationally to assist health professionals provide effective counseling to pregnant women regarding hazards of substances.

PREPARED STATEMENT OF PAUL H. WISE, M.D., DIRECTOR, PERINATAL EPIDEMIOLOGY, JOINT PROGRAM IN NEONATOLOGY, HARVARD MEDICAL SCHOOL

I am Paul Wise, a pediatrician on the staffs of The Children's Hospital and the Brigham and Women's Hospital in Boston, Massachusetts. I am the Director of Perinatal Epidemiology of the Joint Program in Neonatology, Harvard Medical School, and a Fellow in the Division of Health Policy Research and Education, Harvard University. My work is centered on the social determinants of infant health, some aspects of which were recently published in an article on this topic in the New England Journal of Medicine entitled "Racial and Socioeconomic Disparities in Childhood Mortality in the City of Boston." I am a member of the Physicians Task Force on Hunger in America and I am grateful to the committee for the invitation to testify on this important topic.

Infant mortality in the United States has been reduced dramatically over the past two decades. Rarely has the mortality rate of any age group shown such significant improvement over such a relatively short period of time. This experience has been viewed widely as a major success; a testament to America's technical capacity and medical innovation. I too believe this record deserves attention and is worthy of considerable pride.

The question then is why, in the face of this recent experience, is infant mortality in America worthy of concern? The answer, I suggest, lies in two areas: first, the emerging potential for serious deterioration in the infant mortality rate of the general population in this country; and second, the tragic persistence of major racial and social disparities in infant survival in the United States.

It is my view that the period of continuing progress in infant survival is entering a new phase of increasing vulnerability. Our work and the work of others has shown that the driving force behind the recent reductions in infant mortality has been the improved survival of low birth weight babies, due primarily to the development and clinical implementation of intensive technologies. However, it seems clear that this dependency will soon run its course. For as we improved dramatically our capacity to save smaller and smaller newborns, we have done little to reduce the rate at which these high risk babies were being born. In addition, the mortality rate of all infants during the postneonatal period also remains high. We are fast reaching the limits of our technology to save extremely premature infants. It is therefore quite likely that the infant mortality rate will become increasingly dependent upon this postneonatal mortality rate and the birth rate of low weight babies. Because these two persistent problems are closely related to alterations in social conditions, these two components will convey to the infant mortality rate a heightened sensitivity to economic trends and levels of social funding. It is not the failure of medical technology that brings us to this period of increased vulnerability. It is its success, in that it has left more glaring the yet unattended issues of low birth weight and postneonatal mortality; issues which relate directly to policies which assure adequate nutrition.

It is important to remember that our relatively poor international standing in infant mortality is due to our relatively poor low birth weight rate and postneonatal mortality rate. This poor standing is not the product of geography. It is not the product of being a heterogeneous population. Nor is it an issue of genetics. It is my view that it is a product of the life conditions we tolerate and public policies we implement which affect the health of women and young children in our society.

It is my contention that the gains of the past now force us to confront the underlying problems that remain. However, even the gains of the past are presently threatened. An approaching period of enhanced vulnerability is also due to restructuring of the financial base of health care in this country. The medical innovation of the past decade would have had little impact were it not for public policies which determined its functional availability to those in need. Of particular importance has been Medicaid and funds for regionalization. Without special protection, a realignment in access based on an ability to pay could signal the "deregionalization" of perinatal care based on social class, and result in major detrimental effects on the infant mortality rates of all but the wealthiest of our citizens. I am convinced that in the midst of finding lower cost methods of financing health care - a process almost entirely concerned with parameters of adult care - the effective and hugely successful system of caring for high risk infants could quickly begin to unravel.

The persistence of social and racial disparity in the face of significant reductions in infant mortality deserves special attention. National data indicate that while infant mortality rates for all newborns have fallen, social and racial disparities persist, and in some areas have actually worsened. Our recent study in Boston found that high access to tertiary medical services greatly reduced racial and social disparities in infant and other childhood mortalities. This underscored the importance of equitable access to tertiary level medical care for all children in need, and the potentially disasterous consequences of allowing these critical services to be provided on the basis of social class. However, as important as this technical capacity was, it was not sufficient to eliminate fully racial or social disparities in infant mortality. The technologic capacity of modern medicine could not erase the legacy of larger social inequities which continue to shape the living social environment of children and pregnant women. Of primary concern in this regard is adequate nutrition. As a member of the Physicians Task Force on Hunger, I have visited families, hospitals, and other facilities and seen the high toll exacted by inadequate food. This experience has tempered my view of easy solutions, but it has also provided a sense of the intense human suffering my scientifically-derived numbers imply.

This raises a central issue in confronting disparate infant mortality rates in this country. Continued medical advances in no way guarantee reduced social or racial disparities. Policies which foster general improvements in the survival of our nations's infants may not affect, or could even worsen present social and racial disparities.

Equity in infant outcome can only be achieved when inequity is addressed. Much has been stated regarding the detrimental impact of a number of maternal behaviors, including smoking, alcohol and drug abuse. It seems clear that reducing the prevalence of these behaviors could help reduce overall levels of poor birth outcome. However, there is no reason to believe that such an approach will reduce racial disparities in birth outcome. White women smoke more than black; they also drink more than black. There is little evidence to suggest that the reasons for racial differences in the health of newborns lie in the harmful behaviors of their mothers. Rather the source of disparate mortality rates lies in the societal inequities that continue to be associated with race in our society, and that heighten prenatal and postnatal risk of illness, as well as reduce access to appropriate medical care. It is in this sense that the reduction of black infant mortality means more than the mere reduction of a certain number of excess deaths; it relates directly to our more fundamental commitment to a more responsible and just society.

I speak in strong support of policies which eliminate hunger and best assure adequate nutrition for women and infants. It is important to recognize that these policies are perhaps more critical today than at any other time. A public commitment to improved infant survival will have to first deliberately protect the progress of the past two decades. More far-reaching, however, will be those health and social policies which integrate the growing power of medical understanding with our social goals of equity and maximal opportunity; a challenge that has yet to be addressed adequately by national policy.

[Excerpt from Hunger Report, House Select Committee on Hunger, Apr. 29, 1987]

LOW BIRTH WEIGHT, MATERNAL WEIGHT GAIN AND INFANT MORTALITY

Low birth weight is the most significant of many causes associated with infant mortality. In the United States, infants of low birth weight (LBW) are nearly 40 times more likely to die during the first four weeks after birth. Although less than seven percent of all births are LBW, two-thirds of all deaths in the first four weeks occur among LBW infants.

Factors that affect low birth weight (less than five pounds, eight ounces) include length of pregnancy; poor prenatal care; previous complications in pregnancy; birth number; close birth spacing; and mother's age, marital status, smoking and drinking behavior, socio-economic status, and weight gain during pregnancy.

In June, 1986, the National Center for Health Statistics released the first national study of maternal weight gain and pregnancy outcome. It provides evidence of the role of nutrition in the prevention of LBW by documenting that a low weight gain during pregnancy is associated with higher risk of LBW. Although the usual weight gain in a normal pregnancy should be 22-27 pounds, the study found that one in five white mothers and one in four black mothers with pregnancies of at least 40 weeks gained less than 21 pounds.

Many groups of mothers are at-risk of giving birth to LBW babies: women who have low family income, who smoke during pregnancy, who are 35 years of age or older or in their teens, who have less than nine years of schooling, who are having a fourth or higher order birth, or who are unmarried are all more likely to gain less than 16 pounds during pregnancy. Yet, **mothers in high risk groups who gain sufficient weight are less likely to give birth to LBW babies.**

Mean birth weight increases with added weight gain for babies of mothers who smoked during pregnancy as well as for nonsmoking mothers. The increase in birthweight was especially marked for babies born prematurely (less than 37 weeks gestation) to mothers who smoke; for these babies the birthweight was one pound, eight ounces higher for weight gains of 36 pounds than for weight gains of less than 16 pounds.

Similarly adequate weight gain was an important factor in reducing the incidence of LBW babies among teenagers. Almost 20 percent of teenage mothers who gained less than 16 pounds bore LBW babies, but LBW incidence in this group dropped below five percent when the weight gain was 36 pounds or more.

Higher educational attainment is associated with a reduced risk of LBW. When women gain less than 16 pounds during their pregnancy, however, there is no significant difference in the risk of LBW between those with less than high school education and whose who completed college. For all educational levels, the incidence of LBW is signficantly lower for weight gains of at least 21 pounds than for weight gains of less than 16 pounds.

A low pre-pregnancy weight combined with a small weight gain is associated with a very high incidence of LBW. Almost 30 percent of the babies born to mothers weighing less than 110 pounds who gain less than 16 pounds are born LBW. However, as weight gain rises, the disadvantage in birth weight for babies of small women is diminished.

The risk of fetal death ratios is lowered with added weight gain, up to 35 pounds. For the gestational period 32-40 weeks, the risk of fetal death dropped by about half as weight gain increased from 16 to 26-35 pounds.

Racial differences continue to be a significant problem given that black LBW and infant mortality rates stubbornly remain double those of whites. One third of all black mothers in the study gained less than 20 pounds and, for comparable maternal weight gain, the average birth weight of black babies was lower than white babies. Nevertheless, maternal weight gain substantially reduced LBW among black babies.

It is apparent from this study that a healthy maternal weight gain during pregnancy is associated with a lower incidence of LBW among high risk groups. The study consequently lends support to the need for nutrition supplementation during this crucial period of life and growth.

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Congress of the United States
House of Representatives
Washington, D.C. 20515

NEW REPORT ON WIC HIGHLIGHTS PROGRAM'S BENEFITS

Background on the WIC Program

WIC provides a carefully designed package of highly nutritious foods and nutrition education to low income, nutritionally-at-risk pregnant and post partum women, infants and children under age 5. The program serves approximately 3.3 million participants at an annual cost of $1.56 billion. Currently, less than one-half of the potentially eligible women and children receive program benefits.

Background on the National WIC Evaluation

A major multi-year study released on January 10 shows that the Special Supplemental Food Program for Women, Infants and Children (WIC) has significant impacts on maternal and child health. The report outlines findings of a comprehensive, national evaluation conducted over the past five years by the Research Triangle Institute of Raleigh, North Carolina, and Dr. David Rush of the Albert Einstein College of Medicine of Yeshiva University of New York City under contract to the Food and Nutrition Service of the U.S. Department of Agriculture.

The findings indicate significant health benefits for participants, and include new data which indicate that WIC participation reduces fetal deaths, improves prenatal care and reduces premature delivery.

The five-year study was done as part of the ongoing research and evaluation of the WIC program mandated by Congress. The Child Nutrition Act, which provides the authorization for the WIC program, stipulates that up to $3 million a year is to be available to evaluate program performance and health benefits of the WIC program.

Dr. Rush was the principal investigator of the evaluation which consisted of four interrelated studies that were carried out concurrently. The evaluation was designed to assess the effects of WIC on pregnant women, infants, and children.

Major Findings

Effects on Pregnant Women

- Women who participated in WIC had longer pregnancies leading to fewer premature births. There was a 23% decrease in prematurity among less educated white women (less than a high school education) and a 15% decrease among black women with similar levels of education. (Prematurity is one of the leading causes of death among infants.)

- WIC participation resulted in a significant increase in the number of women seeking prenatal care during the first trimester and a significant reduction in the proportion of women with inadequate numbers of prenatal visits. (Early and adequate prenatal care is one of the most important factors affecting pregnancy outcome.)

(over)

- Women enrolled in WIC had improved intakes of many nutrients, including protein, iron, calcium and Vitamin C, nutrients specifically targeted by the program.
- The historical study, one of the four interrelated studies of the evaluation, found an increase in birthweight of 23 to 47 grams. While a second study, the longitudinal study, showed no significant difference in birthweight of WIC babies and non-WIC babies, the longitudinal study did find that birthweight was significantly related to the quality of local WIC program operation. (Note: The longitudinal study was inherently likely to underestimate the effects of WIC benefits on birthweight. The historical study gave a much more secure test of this issue.)
- Women at highest risk (minorities and women with less education) benefited most from WIC.

Impact on Infants and Preschool Children

- WIC participation contributed to a statistically significant decline in late fetal deaths, about 2.3 per thousand births. This represents a 20-33 1/3 percent reduction in the fetal death rate.
- WIC participation also was associated with a reduction in neonatal mortality (early infant death), although this reduction was not statistically significant.
- WIC significantly increased the head circumference of infants whose mothers received WIC during pregnancy. (Head size reflects brain growth.)
- Children enrolled in WIC were better immunized and were more likely to have a regular source of medical care.
- WIC participation appears to lead to better cognitive performance in children. Four- and five-year-old children whose mothers participated in WIC during pregnancy had better vocabulary scores and children who participated in WIC after their first birthday had better digit memory.
- WIC improved the diets of infants by increasing the average intake of iron and Vitamin C and significantly diminishing the frequency of low intakes of iron, Vitamin C and Vitamin A.
- WIC improved the diets of older preschool children by increasing average intakes of iron, Vitamin C, thiamin and niacin and significantly decreasing the frequency of low intakes of Vitamins A and B and riboflavin.
- The greatest dietary benefits were among children at highest risk: children who are poor, short, black or in families consisting only of the mother and the preschool child.

The Effect on Diet

- WIC families buy more highly nutritious foods than non-WIC families.

INCREASING INFANT MORTALITY RATES FOUND AMONG WHITES IN 11 STATES AND NON-WHITES IN 16 STATES IN PRELIMINARY 1984 TO 1985 DATA

Preliminary data gathered by the House Select Committee on Hunger from states by telephone shows increases in infant mortality rates (IMR) affecting 26 states from 1984 to 1985. The increases appear in white and non-white categories. No 1985 data was available from Alaska, California or New Jersey. Three states (Maine, Utah and Wyoming) reported increases in the total IMR with no breakdown.

"These statistics sound an alarm. While the data is subject to further study, the preponderance of evidence from so many states shows clearly that the United States is falling behind in its effort to lower the infant mortality rate," said Chairman Mickey Leland in releasing the material in conjunction with a hearing on the role of food programs in reducing infant mortality.

Eleven states reporting increases in white infant mortality rates are Alabama, Arkansas, Delaware, Florida, Idaho, Iowa, Montana, New Mexico, North Dakota, Pennsylvania and Washington.

Sixteen states reporting increases in nonwhite infant mortality rates were Colorado, Connecticut, Delaware, Indiana, Iowa, Kentucky, Maryland, Minnesota, Massachusetts, Montana, Nebraska, New Mexico, Oklahoma, South Carolina, Tennessee, West Virginia. The nonwhite category includes black, native American, Asian and Hispanic persons.

In addition, four states and the District of Columbia show decreases in the IMR but rates for nonwhites remain unacceptably high at 18 per 1000 live births or above. The states are Georgia, Michigan, Mississippi and Virginia.

The United States ranks 17th in the world in IMR with 11 deaths per 1000. Nations with better 1985 rankings according to UNICEF are (6) Sweden, Finland, Japan, (8) Switzerland, Netherlands, Denmark, Norway, France, (9) Canada, Australia, Singapore, (10) Federal Republic of Germany, United Kingdom, Ireland, Spain.

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INFANT MORTALITY RATES

		84	85	86
ALABAMA	total	12.9	12.6	N/A
	white	9.6	10.4	
	nonwhite	19.0	16.8	
ARIZONA	total	9.5	9.6	N/A
	white	N/A	9.3	
	nonwhite	N/A	11.4	
ARKANSAS	total	11.1	11.7	N/A
	white	9.2	10.9	
	nonwhite	16.7	14.4	
CALIFORNIA	total	8.9	N/A	N/A
COLORADO	total	10.2	9.4	N/A
	white	10.0	9.1	
	nonwhite	12.6	13.2	
CONNECTICUT	total	10.3	9.9	N/A
	white	9.2	8.4	
	nonwhite	17.1	19.1	
DELAWARE	total	10.4	14.5	N/A
	white	8.0	11.2	
	nonwhite	16.8	24.5	
DISTRICT OF COLUMBIA	total	21.2	20.7	N/A
	white	7.8	10.6	
	nonwhite	24.0	22.9	
FLORIDA	total	10.8	11.3	11.0*
	white	8.5	9.2	8.8*
	nonwhite	17.7	17.3	17.7*
GEORGIA	total	13.4	12.7	12.3*
	white	10.1	9.4	
	black	19.5	18.8	
HAWAII	total	10.0	8.7	N/A
	white	8.0	7.3	
	nonwhite	10.6	9.1	
IDAHO	total	9.7	10.4	N/A
	white	9.7	10.5	
	nonwhite	11.5	10.3	
ILLINOIS	total	12.0	11.6	12.1*
	white	9.4	9.1	
	nonwhite	20.4	20.0	

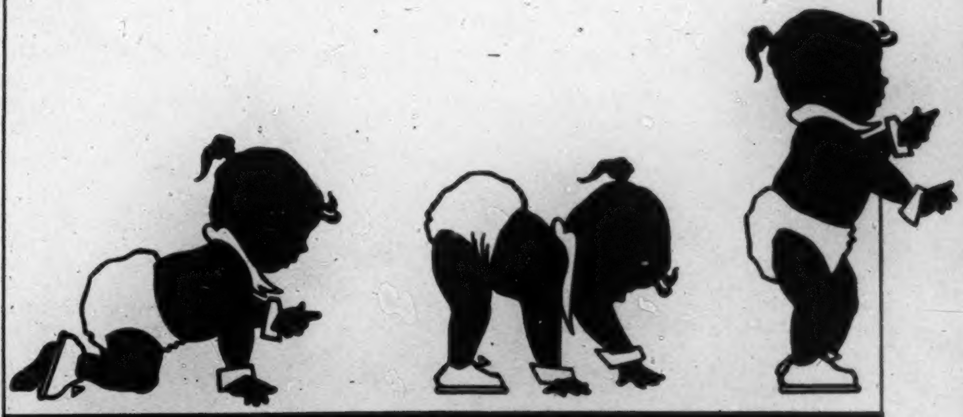
		84	85	86
INDIANA	total	10.5	10.9	N/A
	white	9.6	9.9	
	nonwhite	17.8	19.4	
IOWA	total	8.9	9.4	N/A
	white	8.8	9.4	
	nonwhite	10.0	11.6	
KANSAS	total	9.8	9.1	N/A
KENTUCKY	total	11.6	11.2	N/A
	white	11.0	10.3	
	nonwhite	17.1	19.5	
LOUISIANNA	total	12.1	11.9	N/A
	white	8.9	8.6	
	nonwhite	16.9	16.7	
MAINE	total	8.1	8.9	N/A
MARYLAND	total	11.1	11.9	N/A
	white	9.0	9.0	
	nonwhite	15.1	18.7	
MASSACHUSETTS	total	8.9	9.1	N/A
	white	8.7	8.5	
	nonwhite	14.6	20.0	
MICHIGAN	total	11.7	11.4	N/A
	white	9.4	9.3	
	black	23.5	22.5	
MINNESOTA	total	8.8	8.8	N/A
	white	9.0	8.9	
	nonwhite	6.8	7.6	
MISSISSIPPI	total	14.4	13.7	N/A
	white	9.9	9.3	
	nonwhite	19.2	18.7	
MISSOURI	total	10.3	10.2	10.6*
	white	9.0	9.0	9.2*
	nonwhite	17.0	16.1	17.6*
MONTANA	total	8.8	10.2	N/A
	white	8.9	9.5	
	nonwhite	8.2	15.6	

		84	85	86
NEBRASKA	total	9.6	9.6	N/A
	white	9.2	9.2	
	black	15.4	17.7	
	other	10.9	9.2	
NEVADA	total	11.3	9.3	N/A
	white	11.1	9.2	
	black	16.6	14.3	
	indian	5.2	4.8	
	other	5.7	1.7	
NEW HAMPSHIRE	total	10.2	9.2	N/A
NEW JERSEY	total	10.8	N/A	N/A
	white	9.0		
	nonwhite	17.8		
NEW MEXICO	total	9.6	10.6	11.2*
	white	9.6	10.6	
	nonwhite	9.9	10.6	
NEW YORK	total	10.9	10.7	10.2*
	white	9.0	8.5	
	nonwhite	14.3	13,9	
NORTH CAROLINA	total	12.5	12.0	N/A
	white	10.0	9.5	
	nonwhite	18.2	17.5	
NORTH DAKOTA	total	8.2	8.5	8.3*
	white	7.9	8.4	8.3*
	nonwhite	10.5	9.6	8.4*
OHIO	total	10.4	10.4	N/A
	white	9.2	9.3	
	nonwhite	16.8	16.2	
OKLAHOMA	total	10.5	10.8	N/A
	white	10.5	10.6	
	nonwhite	14.1	18.7	
	indian	6.7	4,4	
OREGON	total	9.8	9.8	N/A
	white	9.9	9.9	
	nonwhite	9.2	8.9	

		84	85	86
PENNSYLVANIA	total	10.4	10.8	N/A
	white	8.8	9.4	
	nonwhite	20.0	18.8	
RHODE ISLAND	total	9.9	8.2*	
	white	9.5	8.0*	
	nonwhite	16.1	11.8*	
SOUTH CAROLINA	total	14.7	14.2	N/A
	white	11.1	9.5	
	nonwhite	20.2	21.4	
SOUTH DAKOTA	total	10.0	9.7	N/A
	white	8.8	8.6	
	indian	17.1	17.1	
TENNESSEE	total	11.8	11.3	N/A
	white	9.8	8.8	
	nonwhite	18.5	19.4	
TEXAS	total	10.4	9.8	N/A
	white	9.4	8.6	
	hispanic	9.9	9.4	
	black	15.9	15.6	
UTAH	total	9.1	9.6	N/A
VERMONT	total	8.8	8.5	N/A
VIRGINIA	total	12.3	11.5	N/A
	white	9.9	9.2	
	nonwhite	19.2	18.2	
WASHINGTON	total	10.2	10.6	N/A
	white	10.1	11.1	
	nonwhite	10.9	9.1	
WEST VIRGINIA	total	11.0	10.7	10.1*
	white	10.8	10.3	
	nonwhite	15.2	18.3	
WISCONSIN	total	9.9	9.2	N/A
	white	9.0	8.4	
	nonwhite	17.6	15.4	
WYOMING	total	11.1	12.2	N/A

*Provisional Data

The American Crisis of Infant Mortality:



Issues & Recommendations

PRESENTATION OF MAYOR RAYMOND L. FLYNN
to the
NATIONAL LEAGUE OF CITIES
Congress-Cities Conference
Washington, DC
March, 1987

CITY OF BOSTON • MASSACHUSETTS

OFFICE OF THE MAYOR
RAYMOND L. FLYNN

The American Crisis of Infant Mortality:
Issues & Recommendations

PRESENTATION OF MAYOR RAYMOND L. FLYNN

to the

NATIONAL LEAGUE OF CITIES
Congress-Cities Conference

Washington, D.C.

March 1, 1987

BOSTON CITY HALL • ONE CITY HALL PLAZA • BOSTON • MASSACHUSETTS 02201 • 617/725-4000

In concert with the Children's Defense Fund, the City of Boston has developed a series of recommendations based on a comprehensive analysis of the recent rise in the rates of infant mortality in America's cities. Sadly, in the wealthiest nation on earth, it is again necessary to turn our attention to infant mortality.

Last month, the Children's Defense Fund once again reminded us that the social safety net has gaping holes when it comes to the health and welfare of this nation's women and children. At that time they noted that infant mortality rates in six of the 22 largest cities in the United States had increased during 1984. In addition to Boston; other cities registering an increase were the District of Columbia, Detroit, San Antonio, Milwaukee, and Cleveland.

That report also noted that this country had fallen to a tie for last place among the industrialized nations of the world in terms of infant mortality. In countries such as Hong Kong, Australia, Japan and Spain infants have a greater chance of survival than those babies born in the United States. For non-white Americans this situation is even more critical. In many of our nation's cities the minority infant mortality rates exceed those of a developing nation.

Infant Mortality: the Most Sensitive Indicator

Infant mortality rates are widely accepted as indicators of a community's overall health and well being. Unfortunately even the City of Boston -- which is distinguished internationally for its system of health care and our advanced medical commitment to combating infant mortality — was one of the six cities with an increase from 1983 to 1984. The infant mortality rate rose from 11.5 to 11.7 deaths per thousand live births.

The 1985 data for the City of Boston indicated an increase in infant mortality from 11.7 to 15.4 deaths per thousand live births. At this time, preliminary examinations of the 1986 figures suggest that Boston's novel prenatal outreach program -- the Healthy Baby Program -- is beginning to put the rate back on the downward trend it was on prior to the intensive period of federal cutbacks in the early years of this decade.

Causes

Low birthweights are indicators of high infant mortality rates. Inadequate nutrition and poor prenatal care are two major causes of low birthweight. While the medical profession has improved its ability to save these infants, progress towards reducing the number of low birthweights has been slow. Infants born under these conditions are 40 times more likely to die within the first year of life. If they survive, their lives are often complicated with a wide range of long term health problems. Early prenatal care can reduce the incidence of low birthweights by as much as two-thirds.

In addition, every dollar spent for prenatal care can save over $3 in the first year of life by reducing the need for hospital stays among infants. Over a lifetime, that same dollar saves up to $11 in total medical expenses because fewer children are born with permanent health problems.

Millions of low-income mothers and children are deprived of prenatal care because they have no health insurance. Between 1978 and 1984, the number of Americans without health insurance increased by one-third or 9 million persons.

While the White House has been cutting maternal and child health programs, the need for those programs has been clearly increasing. Medicaid access for poor and near-poor families declined from 65 percent to 46 percent between 1975 and 1985. During this time, unemployment and poverty rates were on the rise, thereby reducing people's opportunities for access to health insurance.

Poverty & Infant Mortality

This evidence points to the most prevalent factor contributing to the rise in infant mortality rates: POVERTY. The number of women and children living in poverty is at its greatest level in over 20 years. In 1979 programs such as public assistance and unemployment insurance were successful in lifting 1 out of 5 families out of poverty. By 1985 that rate had dropped to 1 in 9, retaining 458,000 families in poverty.

Other program cuts and restrictions contributing to these rates are important to note. In 1976, the Federal Aid to Families with Dependent Children (AFDC) program benefits provided in 46 states equal to 75 percent of the poverty level for a family of three. In 1986, this was true in only eight states. In more than half of the states, AFDC benefits are denied if both parents are present in the home. The average net income of a family receiving AFDC has decreased 40 percent due to the failure of benefit levels to keep place with inflation.

Another program affected by inflation and subsequent cut backs is the Food Stamp program. Between 1982 and 1985 $7 billion were cut from that program. Dr. J. Larry Brown of the Harvard School of Public Health and a member of the City of Boston Mayor's Commission on Hunger, in his recently published article, "Hunger in the U.S." (Scientific American, February 1987), cited nutrition program reductions and their massive impact on worsening hunger for poverty-stricken families. At a time when the federal government recognizes that 33.4 million Americans are living in poverty, only 19 million are receiving Food Stamps.

In addition to the Food Stamp program, the Supplemental Food Program for Women, Infants and Children (WIC) served only 40% of all eligible women and children in 1986. When it comes to poverty, Washington has given a new meaning to the phrase, "women and children first."

Infant Mortality as a Housing Issue?

Additionally, federal funding for the creation of new affordable housing declined by 75% from $33 billion to less than $10 billion between 1981 and the present.

Declining housing supports may seem unrelated to rising infant mortality until one talks to the female single parent who choose among the rent bill, the food bill, or the cab fare as the one that gets paid out of her meager income. These are the families whom the staff of Boston's neighborhood-based health centers see everyday. These centers are the delivery point for the City's Healthy Baby Program which operates with a $1.1 million appropriation from the City of Boston. This program was instituted in the latter part of 1985, when we first became aware of the renewed rise in infant mortality.

The Healthy Baby Program provides prenatal care, public health nurses, nutritional counseling and benefits advocacy to pregnant women in target neighborhoods with high infant mortality rates. During its first full year of operation Healthy Baby reached more than half of the pregnant women who gave birth in the target areas. In addition it provided over 12,000 home visits to the 1,800 women enrolled in the program during this period. Healthy Baby is successful in part because it utilizes the networks and resources of community health centers.

Outreach is an important component of the Healthy Baby Program. Once a woman has sought services at a community health center, she will be assigned a public health nurse and an advocate. This staff reflects the linguistic and cultural diversity of the people they serve.

In Massachusetts, through the leadership of Governor Michael S. Dukakis and the state legislature, we have supplemented funding for the WIC program and provided through the Healthy Start Program, subsidized prenatal care to low income pregnant women who are ineligible for Medicaid and do not have private health insurance.

The combination of Healthy Baby and the state-funded initiatives is making an impact. As noted previously, preliminary statistics available from the City's Department of Health and Hospitals indicated that infant deaths declined in 1986, which was the first full year of implementation of these various programs. For this reason, programs such as Healthy Baby which provide outreach and prenatal care to high risk individuals, and Healthy Start which increases health care coverage, should be considered for implementation on a national level.

Many of the initiatives for which we are seeking your support would increase resources and programs available to community health centers.

Clearly the federal government needs to reclaim the role it has abdicated in providing programs and financial assistance to low income women and their children. Specifically, I ask your consideration of the following recommendations.

RECOMMENDATIONS

Out of the experience of governments on the state and local level, and through that of national, private organizations such as the Childrens Defense Fund, some effective measures have been proposed and implemented. It is timely for national organizations such as the National League of Cities to urge Washington to implement these effective programs at the national level. The following short list is by no means exhaustive. But it includes ideas that, if executed with proper funding, would go a very long way toward giving American infants the chance they deserve for a full and happy life.

1. Support of S.422

This bill is the Medicaid Infant Mortality Amendments of 1987 whose co-sponsors include Senators Edward M. Kennedy and Bill Bradley. This bill, if enacted, would give states the option of providing health care coverage for pregnant women and infants whose income equals between 100 and 185 percent of the official poverty level. It also would expand health care coverage for poor young children.

2. Increase Support for Community Health Centers

Funding for the Maternal and Child Health block grant as well as funding for Community Health Centers programs should be expanded to allow development of health services in all medically underserved areas.

3. Implement Prenatal Outreach through the Public Health Service

The federal government should provide additional funding for the Public Health Service with specific emphasis on more effective outreach efforts to pregnant women and children for prenatal care. All early indications from the Boston experience with the Healthy Baby Program are that this approach can be very effective in reducing the rates of infant mortality.

4. Full Funding for WIC

The federal government also should provide full funding of the WIC program to ensure that all those who are qualified for this program, which provides nutritional supplements and counseling, receive its services.

Conclusion

In conclusion, it is clear that a rise in the rates of infant mortality is a vital indicator that our federal domestic policy is shortchanging the most vulnerable people in our nation: poor women and infants. It is troubling that in the wealthiest nation in the world mayors and others must fight to make the health and well being of newborns a national priority.

An America that is not alarmed by increases in the rate of infant mortality is an America that has lost its vision of true greatness. A nation that is undisturbed by the weak but still piercing cries of a struggling newborn is a nation in danger of sinking into a deep quagmire of apathy.

Especially as the National League of Cities looks to the elections in 1988, we must be vigilant in our advocacy for those who, because of handicaps or income or other circumstance, cannot be heard without our help.

During the past few months much has been said in our nation's capital about welfare reform. I welcome and support this national discussion. I am also concerned, however, because some of the proposals under consideration make little mention of the fact that so many families in America do not have income sufficient to feed themselves, clothe themselves, and put a roof over their heads. We rightfully encourage our low income citizens to seek economic opportunity but at the same time -- especially on the heels of the CDF's findings on increases in infant mortality -- we must as a society provide at least a minimal income security for these families.

Rising infant mortality rates illustrate a tragedy that is occurring nationally. It is a tragedy whose script was written in the lines of the federal budgets that blunted three decades of progress in improving the health status of our citizens.

We welcome the support and leadership of the National League of Cities in urging the Congress and the President to address this critical issue.

NATIONAL ASSOCIATION OF WIC DIRECTORS

April 23, 1987

Mickey Leland, Chairman
House Select Committee on Hunger
507 House Annex #2
Washington, D.C. 20515

Dear Chairman Leland:

I wish to commend the House Select Committee on Hunger for holding hearings on the Role of Federal Food Assistance and Strategies in Reducing Infant Mortality. As the National Association of State WIC Directors we are vitally concerned and committed to seeing that the WIC Program contributes as extensively as possible to the reduction of infant mortality. Nutritious supplemental foods, nutrition education and referral into the health care system, do make a difference in the health of mothers and infants and pregnancy outcome.

To that end, I am pleased to report that State and local WIC Directors have increased Program targeting efforts to serve additional numbers of low income, high risk pregnant women and infants. Program enrollment comparisons between September 1984 and September 1986 indicate a 19% increase in enrollment of pregnant women (Sept 1986 - 511,743 vs Sept 1984 - 429,767 = 81,776). During the same period, infant participation increased by 21.8% (Sept 1986 - 1,123,023 vs Sept 1984 - 919,566 = 203,457). During this two year period, total program enrollment for all women, infants and children, increased by eleven percent.

Findings from the January 1986 five year National Evaluation of WIC provide dramatic and positive findings of WIC's effectiveness:

...less prematurity; significant increases in birth weight; improved dietary intake in all groups; and increased head circumference.

...the largest improvements are seen among those at higher risk (teenage, unmarried, Black and Hispanic origin women).

...WIC as an adjunct to health care, facilitates introduction to earlier and more adequate prenatal care and improved birth outcome.

...and finally in the words of the principal investigator, Dr. David Rush of the Albert Einstein School of Medicine, "the reduction of fetal deaths

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Mickey Leland, Chairman
April 23, 1987
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was significant; this may be the first reasonably secure demonstration of reduction of mortality following a program of feeding during pregnancy."

Other studies have demonstrated WIC's cost effectiveness in reducing costs of newborn health care because of the mother's improved nutrition status during pregnancy.

When Congress established WIC, they wisely directed that it was to function as an adjunct to health care. WIC's effectiveness is significantly enhanced by an adequate,accessible, integrated health care system. Using our own Wyoming WIC Program as an illustration, the referrals made of our existing caseload by order of the number of referrals made are: immunization clinics, well child clinics, prenatal classes, family planning, physician medical care, public health nursing care, food stamps, Headstart, AFDC, dental services, social services, and payment mechanisms for childrens health services. Where health care is inadequate or not available, WIC's effectiveness is compromised.

WIC is responsible public policy as work. Using this Nation's food abundance to support the growing minds and healthy bodies is the Nations' strongest and best National Defense. If we are to be a competitive nation into the twenty-first century, then surely we must commit ourselves to developing our greatest resource - our children.

Yet, less than half of the low income, nutritionally at risk eligible mothers and children are able to participate due to lack of program funding. I trust the Select Committee on Hunger will support modest incremental growth in the WIC Program as a priority investment in reducing infant mortality and protecting this Nation's future.

Respectfully yours,

Joseph T. Williams, R.D., M.P.H.
President

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